

**“I’ll Be Very Dangerous Until Somebody Decides I’m Not.” The Experience
of Transfer from Prison to High Secure Hospital: A Thematic Analysis**

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Thesis Abstract

This study sought to explore how men experienced their transfer from prison in the criminal justice system, to being detained indeterminately in mental health services, under the Mental Health Act, for treatment and rehabilitation.

An exploratory qualitative method using thematic analysis was adopted throughout the research process. Eleven participants were recruited with each participant engaging in one semi-structured interview. The data was collected and analysed employing a six-stage process, following the guidelines by Braun and Clarke (2006). Four main themes were constructed, with some themes consisting of smaller subthemes: *Shifting Identities*, *Understanding and Negotiating*, *Engaging with Therapy*, and *Making Sense of Time*.

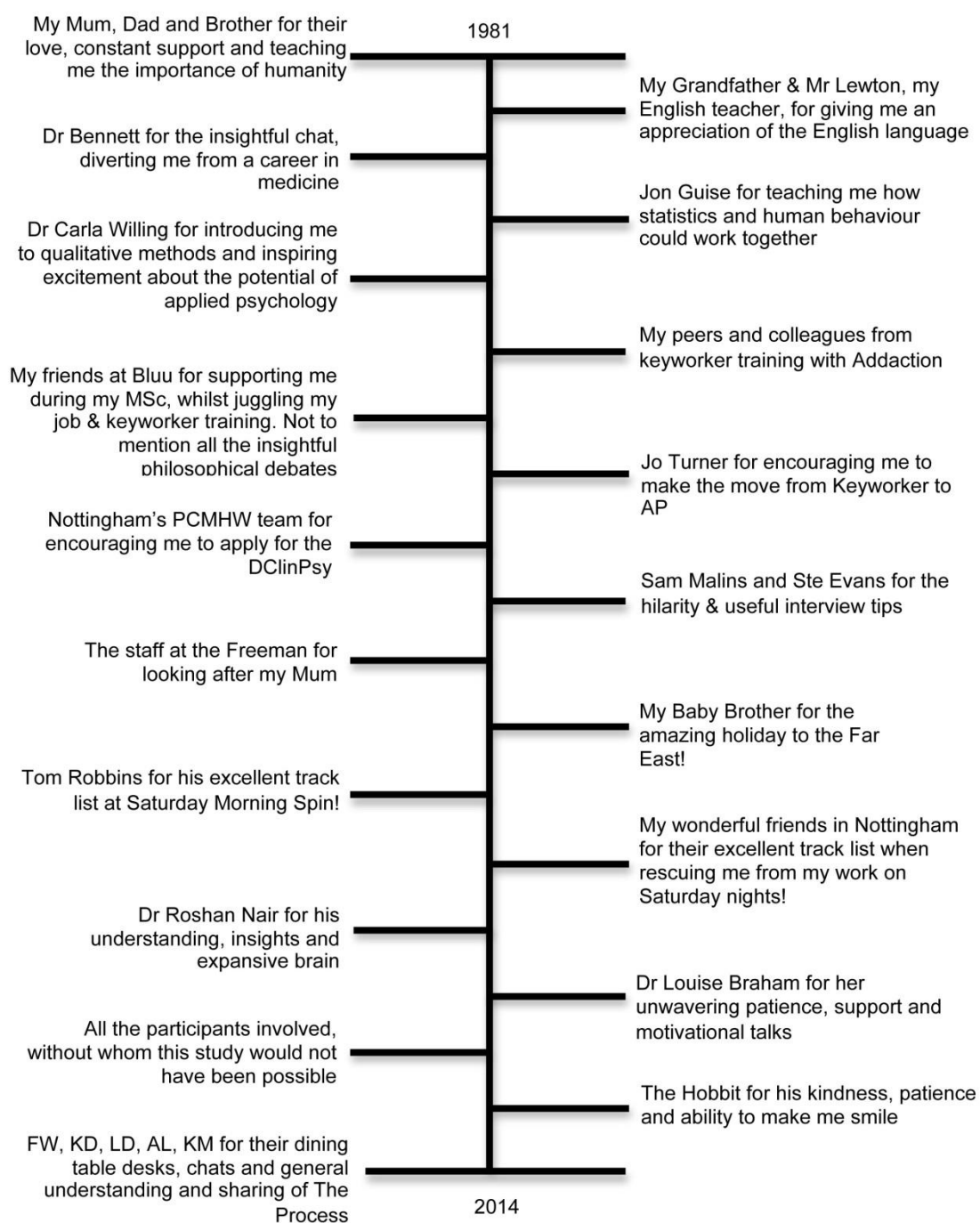
The core of the thematic analysis constructed suggests that individuals found that the process of transfer had a direct impact on their perception of self, causing shifts in identity. The main features which supported their view of self was that of 'being a patient' in a system; a system which held power to make important evaluations about them as individuals. This linked directly to a second theme where participants described a process of familiarisation and adaptation to their environment. This was constructed as a strategy which supported participants to set up assumptions and expectations about being detained for treatment in a high secure hospital. The process of transfer and adjustment was underpinned by existing hierarchies of power.

This research offers a unique contribution to the current literature by illustrating that the process of transfer has a significant effect on individuals, highlighting the need to support individuals to make sense of this process and their new environment.

Given the limitations of the study future research incorporating a wider constituency of participants, including those who may have moved on from high secure services would add useful insights into this experience. The clinical implications suggested by the study include the need for psychological therapy in this setting to focus more upon the impact of transition, with wider consideration by clinicians of the impact of social identity on the process of treatment and rehabilitation for this population.

Acknowledgements

There have been many people with whom I have crossed paths that have made this possible. Unfortunately, there is not enough time or space for me to thank them all. Below is a small nod to the few. To the many more I would like to say that I am simply grateful....



Statement of Contribution

Sunita Guha was responsible for the design of this project, applying for ethical approval, reviewing the relevant literature, recruitment of participants, data collection, analysis and writing up of the research.

Both Dr Roshan das Nair and Dr Louise Braham provided supervision and guidance throughout the research process. Dr Louise Braham offered both advice on the design of the study and support during the early stages of conceptualising this research.

Dr Roshan das Nair assisted in the development of the thematic map and analysis of results.

Recruitment of participants for the research was supported by Responsible Clinicians and staff at the high secure hospital referred to in the study.

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Systematic Review

Mad or Bad? The Experience of Mental Health Problems in the Criminal Justice System

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Abstract

There are high rates of mental health problems in the criminal justice system (Sainsbury Centre for Mental Health, 2006). Responsibility for prison health care in the UK lies with the NHS and aims to give prisoners access to the same quality and range of health services as the general public receives in the community. This is an enormous challenge as little is known about how people conceptualise their experience. The aim of this review is to use the findings from existing studies to gain further understanding of this experience. Three main databases were electronically searched in August 2011. Using thematic synthesis, studies involving primary research were reviewed and descriptive and analytic themes then extracted. The main findings of the review found four key themes of Systems, Identity, Personal Meaning and Relationships were important in understanding this experience.

Introduction

In Britain the prevalence rate of mental health disorders in the prison population is significantly higher than in the general population (Sainsbury Centre for Mental Health, 2006). With estimated rates being as high as 90% (Singleton, Meltzer, Gatward, 1998), which is over 10 times higher than in the general population (Brugha et al., 2005). From a treatment perspective, knowledge about the ways in which individuals process their subjective experience whilst detained is crucial in developing effective treatment plans.

Despite the significant numbers of people in prison and secure hospitals with mental health problems, very little is known about how people go through such an experience. As they are legally detained it is thought that their ability to exert choice and control over their situation is limited, which in turn may impact on their ability to promote independence and autonomy. In addition there is the effect of the loss of liberty which may impact the ability to foster hope and optimism and ultimately has an effect on the person's psychological wellbeing.

Understanding the experience of having a mental health problem can only be understood by asking those who live with it as a part of their life. By exploring how people conceptualise the experience of mental health problems we can understand how people construct their realities and the meaning they assign to the experience.

This review comes from the observation that grounding of research in this population mainly comes from the positivistic paradigm. Studies have aimed to understand concepts of quality of life, autonomy, control, self-esteem, engagement (Blatier, 2000; Camfield & Skevington, 2008; Ferguson, Conway, Endersby, & MacLeod, 2009; McCarthy & Duggan, 2010) to name a few. However this has been done from a perspective which predetermines the results to categories defined by the very tools that are used to measure change. Without asking the population the research is concerned with about their own subjective perspectives, it cannot be clear whether these concepts are values of those to which research is being applied.

This review hopes to understand the subjective, salient issues of living with a mental health problem whilst being legally detained, by bringing together the findings of individual qualitative studies in this field. It is recognised that synthesising the findings of different studies is a contentious issue, with arguments rejecting the idea that studies can be generalised from the context in which they were conducted (Campbell *et al*, 2003). This review takes the position that synthesising qualitative research does not detract from the need for individual studies to capture individual experience and context, but hopes that using the findings of several studies can add to the body of knowledge in this area (Campbell *et al.*, 2003). From this, guidance can emerge on relevant issues influencing individual psychological responses to the environment from the individuals themselves. It is hoped the findings can then be used to as a starting point for future intervention planning, service development and provision.

Aim

The aim of this review is to use the findings from multiple studies to gain further information about the subjective experiences of prisoners with mental health issues. It is hoped that synthesising the findings from these studies will identify common themes acknowledged by people suffering with mental health problems who have been legally detained.

Search Strategy

A literature search was conducted in August 2011 utilising three electronic databases – PsychINFO, Medline and EMBASE, using a range of search terms

relating to the aim of the review. In addition to this, the Cochrane Collaboration and the Campbell Collaboration of Systematic Reviews were also searched.

The range of keywords and subject headings were grouped into four main areas of 'prisoner'; 'mental health'; 'experiences'; and 'qualitative research'. Where possible, terms were exploded to include different words for the same concept. Free-text search terms were used for concepts not included in the database. Terms for qualitative research were extended to include specific methodologies and a qualitative filter was not used (see Appendix A for specific searches). This is because it has been noted that there is a lack of indexing of qualitative research in electronic databases (Hughes, Closs & Clark, 2009).

In order to address the aim of the review, studies were included if they:

- Were peer-reviewed primary research articles.
- Included male prisoners with mental health problems as participants. It was decided that studies conducted in prison or secure mental health settings (detained under the Mental Health Act) would be included. If staff views were part of the study, only the information from prisoners would be used.
- Explored experiences and perceptions about mental health issues.
- Used a qualitative methodology. It was decided that studies which used a mixed methods design would be included, however, only the qualitative data would be focussed upon in this review.

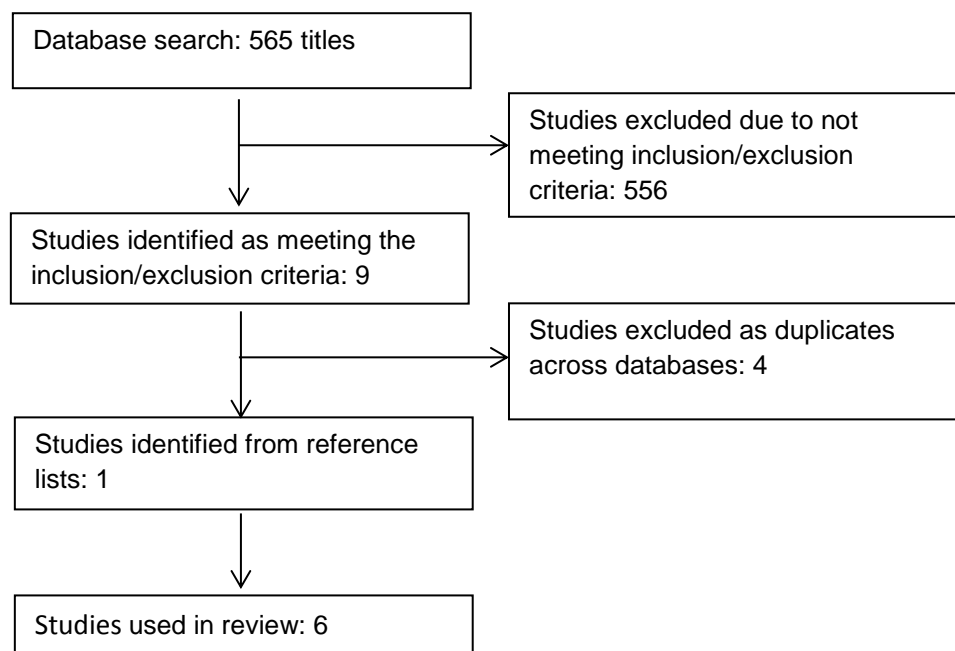
The reference lists of the relevant studies were searched to identify any further literature which may not have been identified by the databases.

From the databases a total of 565 papers were produced. The titles of all papers were then reviewed for relevance. If the title did not give a clear indication of relevance, the abstract was reviewed. The majority of papers were excluded at this stage, as they did not specifically concern male prisoner experiences/perspectives.

This process yielded a total of 21 papers which were then considered further. The abstracts of these 21 papers were obtained and read, leading to 5 papers

which met the inclusion criteria of this review (Livingston, Rossiter, and Verdun-Jones, 2011; Mitchell & Latchford, 2010; Skelly, 1994; Yang, Kadouri, Révah-Lévy, Mulvey & Falissard, 2009; Yorston & Taylor, 2009). One additional paper was identified from checking reference lists (Arrigo, 2001). The flowchart in Figure 1 outlines the search process. A review paper on service user views in forensic mental health services was also identified (Coffey, 2006) and was used as background material.

Figure 1 – Flowchart of Search Process



A total of six papers were used to inform the findings of this review. It was recognised at this stage, some papers focussed on specific areas of mental health, such as ‘forensic labelling’ (Livingston *et al.* 2011) or on specific age groups, such as over 60s (Yorston & Taylor, 2009). In order to come to a decision about whether to include these studies, two areas were considered – how relevant are these factors in experiences of mental health; and how do they contribute to the aims of the review? These specific issues were deemed relevant to how people experience or perceive mental health issues. In addition, it was felt that this review should find a balance between broad and narrow views of mental health, so it was decided the studies would be included in the review.

Quality Assessment of Included Studies

It has been agreed that sound research requires a rigorous and systematic approach to the design, implementation, data collection and data analyses of a study. However, the methods developed for assessing quantitative research are inappropriate for qualitative data, as the evaluation criteria need to be consistent with the philosophical position which informs the research (Fossey, Harvey, McDermott, Davidson, 2002).

The use of quality criteria for qualitative studies is much debated and no consensus has been reached on whether to apply criteria, which criteria to apply and how to apply them (Atkins, Lewin, Smith, Engel, Fretheim & Volmink, 2008). The two most documented quality criteria used in other qualitative reviews have been the Critical Appraisal Skills Programme (CASP, 1998) and the quality assessment framework published by UK National Centre for Social Research (Spencer, Ritchie, Lewis & Dillon, 2003). However, a study by Dixon-Woods *et al.* (2007) comparing the two frameworks alongside unprompted judgement, showed that there was little consistency amongst reviewers of 12 papers. However, the study also highlighted that in using the frameworks, reviewers were able to be more explicit about the reasons for their judgements.

Leading on from the debate of assessing quality of qualitative papers, there has also been a lack of agreement of once assessed, how should that information be used? Some argue that weak qualitative papers should be excluded (Campbell *et al.*, 2003) and others take the view that all research has something to add to the body of knowledge (Dixon-Woods & Fitzpatrick, 2001).

For this review, the quality assessment published by the UK National Centre for Social Research (Spencer *et al.*, 2003) was used to evaluate each of the six studies. This was because the framework not only looks at the quality of the sample and methods, but also focuses upon the impact of the findings in greater detail than the CASP (Dixon-Woods *et al.*, 2003). In order to apply the criteria set out by the framework to the six studies, a grading system from A-D was used: A) No or few problems B) Some problems C) Significant problems and D) Unreliable. This allowed for papers to be graded on a scale of A-D, with the review using main concepts found in papers graded A and B, papers graded

C being used for supporting data and papers graded D to be excluded (Dixon-Woods *et al*, 2006). The grades of each paper are shown in Table 1.

Table 1: Critical Appraisal of Studies

		Study Code					
	Appraisal Question	1	2	3	4	5	6
1	How credible are the findings?	B	C	B	A	B	B
2	How has knowledge/ understanding been extended by the research?	B	C	B	A	B	B
3	How well does the evaluation address its original aims and purpose?	B	C	A	A	B	B
4	Scope for drawing wider inference – how well is this explained?	B	C	B	B	B	C
5	How clear is the basis of evaluative appraisal?	C	D	C	B	B	B
6	How defensible is the research design?	B	C	B	B	B	B
7	How well defended is the sample design/ target selection of cases/documents?	B	D	B	A	A	A
8	Sample composition/case inclusion – how well is the eventual coverage described?	B	D	B	B	B	B
9	How well was the data collection carried out?	C	D	B	B	C	C
10	How well has the approach to, and formulation of, the analysis been conveyed?	A	D	B	B	C	C
11	Contexts of data sources – how well are they retained and portrayed?	B	C	B	C	C	C
12	How well has diversity of perspective and content been explored?	C	B	A	B	B	C
13	How well has detail, depth and complexity (i.e. richness) of the data been conveyed?	B	C	B	B	C	B
14	How clear are the links between data, interpretation and conclusions – i.e. how well can the route to any conclusions be seen?	C	C	B	B	C	B
15	How clear and coherent is the reporting?	C	C	B	B	B	B
16	How clear are the assumptions/theoretical perspectives/values that have shaped the form and output of the evaluation?	C	C	C	C	B	C
17	What evidence is there of attention to ethical issues?	D	C	B	B	B	C
18	How adequately has the research process been documented?	C	C	B	C	C	C
Overall grade		B	C	B	B	B	B

General Characteristics of the Studies

For each study the author, year, aims of study, participants, method of data collection, method of analysis and key findings were put together in Table 2. This table also assigns each study with a code number, which will be used to refer to the study in the review findings.

Table 2: General Characteristics of the Studies

Author, Year and Title of Paper	Study Code	Aims of study	Participants	Method of Data Collection	Method Of Analysis	Findings
Skelly, C., (1994), From special hospital to regional secure unit: a qualitative study of the problems experienced by patients. Location: UK	1	<ul style="list-style-type: none"> To discover the extent of the problem of readmission within one special hospital. To describe the nature of the problems experienced by people in regional secure units. To generate a theory to explain why some patients experience 'failure'. 	N = 14 male (7 diagnosed with suffering from mental illness, 7 diagnosed with psychopathic disorder. All on restriction orders of the Mental Health Act 1983 and convicted of serious offences)	30mins – 1hr semi-structured interviews	Grounded theory Constant comparative method (Glaser and Strauss, 1967)	<ul style="list-style-type: none"> There appeared to be a high rate of return from secure unit to special hospital after discharge/transfer. A 43% rate of return was calculated. The nature of the problems experienced by people in regional secure units was categorised into five areas – 'getting out', 'backward step', 'playing the game', 'return commission and omission' and 'circumspection'. The focus of the themes was mainly around being transferred between the mental health system, prison system and society. 'Playing the game' was the theme which was focussed upon to develop the theory. However it was recognised by using the patients' experience only to generate the theory, the limitations of the processes of the system was not considered.
Arrigo, B.A., (2001). Transcaration: A constitutive ethnography of mentally ill 'offenders'. Location: Pennsylvania	2	Applying Constitutive Theory to three case studies in order to define the realities of each case presented. Using ethnography to apply the selected principles to the three case studies.	N = 3 (1 female, 2 male) (Typical mental health citizens')	Interviews with researcher	Ethnography	The use of language and the agency-structure duality produced a reality which limited the change of identity and role of the participants.

Author, Year and Title of Paper	Study Code	Aims of study	Participants	Method of Data Collection	Method Of Analysis	Findings
Yorston, G. & Taylor, P.J. (2009). Older patients in an English high security hospital: A qualitative study of the experiences and attitudes of patients aged 60 and over and their care staff in Broadmoor Hospital. Location: UK	3	To examine the experiences and attitudes of patients aged 60 and over who are resident in a high security hospital and their care staff.	N = 12 (11 male and 1 female) (9 were detained under a hospital order with restrictions on discharge [Sections 37/41] of the Mental Health Act 1983, 1 was transferred [Notional Section 37], 1 was held under Criminal Procedure Act 1991 and 1 was under a civil treatment order (Section 3). One person had been admitted due to serious self-harming behaviour, but all others had committed a serious offence)	Unstructured interviews using in-depth interview technique (Marshall & Rossman, 1995)	Qualitative data analysis using methods described by Miles and Huberman (1994)	The four emergent clusters were labelled as 'quality of life', 'vulnerability', 'risk to others' and 'external resources'. It was also noted that people showed awareness of political and funding issues affecting their care.
Yang, S., Kadouri, A., Révah-Lévy, A., Mulvey, E.P., Falissard, B. (2009). Doing time: A qualitative study of long-term incarceration and the impact of mental illness. Location: France	4	<ul style="list-style-type: none"> To understand the meaning of long-term imprisonment and the impact this may have on later adjustment to life in the community. An exploration of potential difference in experiences between individuals with or without mental disorder. 	N = 59 male (On average participants had served 13.2 continuous of jail or prison time. 6 people were identified as Severely Mentally Ill [SMI] and results were compared with 15 people with no psychiatric disorder.)	2 hr interview with two clinicians present (included diagnostic interview using Mini-International Neuropsychiatric Interview [MINI v.5])	Thematic analysis and principles of Grounded Theory (Corbin & Strauss, 2008; Glaser & Strauss, 1967). Computer-assisted linguistic analysis using ALCESTE software.	<ul style="list-style-type: none"> Six categories were identified in relation to the participants' responses. These were 'the outside world', 'others', 'punishment', 'time', 'affects and impulses' and 'self-concept'. The ALCESTE programme also identified 'speech' as a seventh category. It suggested that long-term incarceration has an impact on psychological state of people. The data showed variations in the interpretation of the prison environment in the presence or absence of a SMI.

Author, Year and Title of Paper	Study Code	Aims of study	Participants	Method of Data Collection	Method Of Analysis	Findings
Mitchell, J., & Latchford, G. (2010). Prisoner perspectives on mental health problems and help-seeking. Location: UK	5	To explore and identify common perceptions held by prisoners about mental health problems and sources of support.	N = 12 male (7 were residents on the vulnerable prisoner wing, 5 from the normal wing, 2 people were on remand, the others serving sentences from a few weeks to life.)	Interviews using Personal Construct Psychology (PCP) technique of 'controlled elaboration' (Green, 2005).	Content analysis (Smith, 2000)	A wide variety of problems were identified by interviewees, including those seen in others and those experienced by themselves. The perspectives of mental health problems identified by people were a combination of recognised mental health problems and problems traditionally seen as affecting mental health, rather than mental health problems <i>per se</i> . The study identified 10 the most frequently mentioned problems by participants. The analysis shows that structural factors influence the subjective experiences of self-stigma. Four themes of 'group of criminals'; 'system designed for criminals'; 'rejected'; and 'Cadillac services emerged.
Livingston, J.D., Rossiter, K.R., & Verdun-Jones, S. N. (2011). 'Forensic' labelling: An empirical assessment of its effects on self-stigma for people with severe mental illness. Location: Canada	6	To examine and compare the level of self-stigma that is experienced by people who receive compulsory community-based treatment services in the forensic and civil mental health systems of British Canada.	N = 91 male (52 forensic, 39 civil. All participants were certified under the BC civil Mental Health Act or adjudicated 'Not Criminally responsible on Account of Mental Disorder' under the criminal code of Canada.)	Mixed methods. Qualitative data was collected using semi-structured interviews.	Thematic analysis (Braun & Clarke, 2006)	

Aims

All six studies explored prisoners' experiences of mental health issues, however, two studies (1 & 6) looked at specific concepts of transfer from special hospital and secure unit and the effect of self-stigma. It was felt that these elements contributed to the experience of living with a mental health problem within the context of the criminal justice system and so added another dimension to experiences of individuals which may not have been covered otherwise. It was felt that the aim of each study was clear and the findings of each study addressed the original aims.

Sample

Together the papers use data collected from 191 participants within criminal justice systems worldwide. The aim of the review was to look at male experiences, however, studies 2 and 3 report one female participant in each. Due to anonymising of data, it was not possible to remove this data from the synthesis of findings from the paper. Each study gave varying amounts of data on demographics, diagnosis, length of detention (and time served), offence index – only studies 3 and 4 gave a full description of these areas. This information would have been useful to explore whether diagnosis, length of detention and offence index had any impact on people's experiences of mental health issues.

The sample was comprised of participants from different settings including special hospital and regional secure settings (study 1, 2, 3 & 6); prison (study 2, 4 & 5); civil health settings (study 6); and when homeless (study 2). As the studies covered a number of different settings, the generalisability of the experiences may be limited to some extent, however, all settings, except when homeless, have the shared theme of participants being a part of the criminal justice system. It is this commonality which was used to link the studies. Additionally, it was for this reason the context of homelessness was included, as the participants' involvement in the criminal justice system had led to homelessness.

Ethical Issues

Only three of the six studies explicitly state that ethics committee approval and informed consent was sought from participants (studies 3, 4 & 5). Although issues of confidentiality and anonymity were considered, either explicitly or implicitly (through the way quotations were presented in studies) the discussion of ethical issues was lacking in the studies. None of the articles considered the effects of taking part in the study for participants or spoke about further support if required. In addition, none of the articles in this review considered the issues of power, control and validity of the consent received from a group of literally captive participants. These are concerns often raised by researchers working in this area and when considered can add a level of reflexivity to the findings of the study.

Data collection

All studies used face to face, semi-structured interviews of varying length to collect information from the participants. Only study 1 audiotaped the interview, with the other four studies using verbatim transcription (study 2 & 4) or field notes (3 & 6) to record information. Although studies 3, 4 and 6 stated that this was due to institution policies, there was little acknowledgement in any errors which may have been made in gathering data in this way. Study 5 failed to comment on how the data from the interview was preserved for analysis. These forms of data collection are important to bear in mind when looking at the findings of the studies where direct quotations are used (studies 1, 2, 3, 4 & 6). None of the studies commented upon how raw data was preserved.

All studies suggested that the interviews were participant led and only study 4 explicitly stated the predetermined questions for interview. As interviews were described by the studies as being 'semi-structured' in nature, this lead to the belief an interview schedule was in place. It would have been useful to have knowledge of the interview schedule to make the links between the interview and data analysis more transparent and would have also made clear if the interview schedule was in line with the original aim of the studies.

Data Analysis

Although each of the studies described their underlying theoretical background, none of them justified their reasons for undertaking the analysis of data using that perspective. The theories used a variety of qualitative methods, ranging from grounded theory (studies 1 & 4), ethnography (study 2) thematic analysis (studies 4 & 6) and content analysis (study 5). Only study 4 did not specify the qualitative method used stating it was a form of 'qualitative analysis by methods shown by Miles and Huberman (1994)'.

Most studies used in the review (studies 1, 3, 4, 5, 6) give an indistinct account of how the coding of data and the categorisation of themes was arrived at, with a minimum of two people coding the data. Study 2 did not use this process to arrive at its final findings and, although the method used for data analysis is not as transparent as the other studies, it is the only study which comments upon the subjectivity of the researcher as having an impact on the analysis. Interestingly, none of the studies commented upon the role or views of the researchers and what impact this would have on the analysis of data. Whether this idea was implicit by the very means of undertaking a qualitative methodology is an assumption that is made by this review.

The use of direct quotations vary throughout the studies, from being absent (study 5) to longer contextualised extracts (study 2). The majority of the studies use short quotations to illustrate how the words and experiences of the participants have been interpreted into the analysis. None of the studies report using negative cases or outlying evidence to refine their analysis.

Wider Impact

All studies referred to their findings in relation to existing prior knowledge and how the findings have enhanced understanding of this research. They also all acknowledge the context of the services in producing the accounts they report on. However, none of them apply this knowledge in relation to alternative perspectives which could be employed. Of all the studies, only study 2 explored the context in which the accounts were produced, rather than taking them simply at face value.

All the studies considered the structural implications on an individual's experience and suggested how their study could enhance the lives of people in these services. However, only study 5 took this a step further and considered the implications the study may have for policy development.

Synthesis of Findings

Methods to bring together the findings of qualitative research have been a matter of debate with a number of methodologies, such as meta-ethnography (Noblit & Hare, 1988), critical interpretive synthesis (Dixon-Woods *et al*, 2006) and 'metasynthesis' (Sandelowski & Barroso, 2007) to name a few as suggested ways to integrate findings. As yet, there has been no decision made to which method is the most appropriate for reviews using qualitative studies, with the ultimate debate continuing about whether the findings from one study can be removed from its context and time, to be generalised. This is an important debate when considering the epistemological position of qualitative research, however is an argument to hold in mind, and not contested by this review. The position that this review will take is one of pragmatism, which considers that there has been a case made for qualitative research to be valued to inform policy and practice (Campbell *et al*. 2003; Popay, 2006) and that methods are required to bring together findings from single qualitative studies in order that findings can be used in a wider context. Naturally this has to be done in a way that respects and preserves the complexities of the context of the research (Thomas & Harden, 2008).

This review will use thematic synthesis to bring together the findings of the six studies (Thomas & Harden, 2008). This approach uses techniques found in 'thematic analysis' and aims to identify, develop and formalise themes from the studies. This way of interpreting findings of qualitative studies aims to extract 'descriptive themes' from the primary data in a transparent way, which allows the findings to remain 'close' to the original studies. It then uses a level of interpretation by the reviewer to generate new constructs or explanations.

Data extraction and thematic synthesis

All sections labelled 'results' or 'findings' were used in the thematic synthesis. It was originally planned to only extract and use findings linking to the direct

experiences of mental health issues from the studies, as outlined by the aim of this review. However, on reading the studies, it was recognised that concepts were interlinked and hard to separate and that approaching the studies with this preconceived framework may limit the review findings. For this reason, it was decided that the starting place for the themes would be from the findings of the studies themselves.

The studies were arranged in to chronological order and first read independently. This was followed by further readings to identify key themes in each study, which generated a list of 'descriptive themes', which remained close to each study. The final stage was to identify further themes which captured the descriptive themes and would finally make up the 'analytical themes' of this review. This last process was repeated in a cyclical manner to produce analytic themes which could explain the original themes of the studies.

Findings

The review found that the experience of having a mental health problem whilst legally detained is a complex construct which is difficult to define. It was clear from the studies which focused on specific areas of mental health, such as age (study 3) and stigma (study 6), that even when focusing on a narrow aspect of mental health a number of different themes arose depending on the emphasis of the interview. There appeared to be four main themes of Systems, Identity, Emotions, Personal Meaning and Relationships, which linked the findings of the studies. Although these four themes were identified, it was noted that the studies often referred to differing aspects of these themes and this is discussed in further detail below. The descriptive themes which lead to the four analytical themes are shown in Table 3.

Table 3: Table of Descriptive and Analytical Themes

Analytical themes	Descriptive Themes	Study Code					
		1	2	3	4	5	6
Systems	Power and control	Y	Y	N	N	Y	Y
	Institutionalisation	Y	Y	N	Y	N	Y
	Political agenda	N	N	Y	N	N	N
	Moving on	Y	N	Y	Y	N	N
Identity	Shaped by language and discourse	N	Y	N	N	N	Y
	'Mad or Bad'	N	Y	Y	N	Y	Y
	Risk	Y	Y	Y	Y	Y	Y
	Change	Y	Y	Y	Y	N	N
	Perceptions of others	Y	Y	Y	N	N	Y
Personal Meaning	Work vs Play	Y	N	Y	N	N	N
	Loss of opportunity	Y	Y	Y	Y	Y	Y
	Punishment / Restrictions	Y	Y	Y	Y	Y	Y
	Timelessness/ Waiting	Y	Y	Y	Y	Y	N
Relationships	Outside world vs Inside world	N	N	Y	Y	N	N
	Concepts of family	N	N	Y	Y	N	N

Systems

Throughout the studies participants acknowledged the reality of being entwined in a system which asserted power over them, whether this be through 'playing the game' (study 1, 2, 4) and complying with the rules around them or through the very structure of the institutions and the care that they received (study 4, 6). There appeared to be a strong sense of the power of the institution and what this meant for individuals:

"If I didn't want to do something and I argued about it they could send me back and for that I was worried about those sort of things all the time, that they'd send me back." (Study 2)

"Not really a hospital. More like a jail. Treated more like a criminal." (Study 6)

Conversely, although people were aware of the system around them, in some studies there was an awareness of how to manipulate the system (Study 1, 4). Participants seemed aware of the control they could exert over some aspects of the situation they were in:

"I'm going to refuse to continue, not out of despair but to protest. I will go on a hunger strike, because an entire life in prison, that has no meaning. This

situation leads nowhere, because it has no meaning at all. It's not easy to handle.” (Study 4)

The organisational factors in which people exist implied a level of institutionalism for some people. This was an element of life which was made clear in the area of investigation for study 1 – which focused primarily on the transfer of people from special hospital to regional secure unit. However, studies 2, 4 and 6 also made clear that in being part of a system it was difficult to then move on from either due to prejudice by society or by the very nature of the sentence:

“Service providers were afraid of me and thought that I was a violent person. The idea that I was institutionalised, not allowed out of hospital, supervised all the time would make people question ‘why was he locked up?’ and talk about me more.” (Study 6)

These thoughts are similar to those of Goffman's (1961) notion of total institutions in that involuntary hospitalisation was thought of as oppressive.

Interestingly, only participants in study 3 referred explicitly to the political agenda which shaped their legal detention. It was unclear if this was due to the fact that study 3 took place in a high secure hospital, where the legal system and mental health system are heavily intertwined.

Despite the sense of institutionalism there was also reference to moving on from where people were (studies 1, 3, 4). However, this took different guises with participants in studies 1 and 4 thinking about a life outside and those in study 3 talking about death. This was, however, noted as unusual by the researchers.

The notion of systems around an individual also linked in with the theme of the ‘Outside world vs Inside world’ where participants were aware that there was a system in which the system they were a part of existed, but this is discussed in more detail under the theme of Relationships.

Identity

The theme of Identity was heavily shaped by the language and discourse used by the participants in all the studies. However, only studies 2 and 6 referred to this explicitly. This was thought to be due to the topics of emphasis of each

study. Despite this, it appeared that some of the participants viewed themselves as 'mad or bad' (studies 2, 3, 5, and 6):

".....Now I know that I am guilty, and I know why I am here...I huge difference in relation to the beginning: I know who I am and I know why I am here." (Study 4)

"I hide it [forensic status]....I tell people I went to Kent [a maximum security correctional facility] and have probation. I don't associate with forensic because of embarrassment. My friends and family would label me 'mental'." (Study 6)

Study 2 makes the explicit link between the labelling of people through discourses and language and how this will affect one's identity. The ethnography study demonstrates how the language used around people restricts them in becoming anything else. The thread of 'mad' or 'bad' was defined through implicit meanings in the studies and the lack of any other ways of conceptualising identity other than 'criminal' or 'forensic' (study 6), 'prisoner' or offender' (study 1, 2,4) or 'crazy and insane' (study 5). Only in study 3 did participants refer to themselves as 'patients', which allowed another identity to be offered to the participants in this review.

However, the intrinsic meanings in language did not take away from the real risk felt from others in this population. Some participants referred to people being scared of them (studies 1, 2, 3, 5, 6) but also the risk they faced from others in their environment (studies 3, 4, 5). People spoke of being both assaulted and bullied and there was a sense of resignation about this as reality across the papers:

"in prison, I've had physical assaults....There are some who make me afraid, because me, I'm a nice guy, a real one, so they want to take advantage and swipe stuff from me, That's hard everyday." (Study 4)

Study 5 also referred to self-harm and suicidal thoughts, but due to the brevity of the reporting of findings, it was difficult to locate these issues of risk within the context of the participants.

The elements of the discourse of risk were heavily linked to the perception of others within this theme of identity. Participants both pre-empted or experienced negative evaluation from others from both inside the system and out, but also

had a need to be perceived as not vulnerable, and in some cases even aggressive:

“There are some in here who come looking for me, I’ve been subjected to violence. But now I’ve warned everyone, if I sense that they’re trying to kill me or harm me, I’ll kill the person in front of me without thinking about it. They won’t be able to say that they weren’t in the know.” (Study 4)

This complex way of forming ones’ identity demonstrates the multiple layers which exist in the world of being legally detained. The number of different sides to each person’s identity cannot be captured by these studies alone, but give an indication of the number of factors that an individual has to ‘hold in mind’ when living in an environment for people with both mental health problems and criminal convictions.

Finally, in creating or being created an identity, the notion of change was also acknowledged in studies 1-4. This appeared to be in the way of reflection and how things had been ‘before’ and ‘after’ (study 1, 4). For others it was in the context of after prison (study 2, 3) and some expressed a preference for the prison environment (3). In such different meanings of change it can be seen that the intricacies of the concept are difficult to remove from the context from which it was taken:

“Today I am working on myself, I regret, I am conscious of the crime, of the wrong that I have done. At the same time that doesn’t prevent me from looking ahead. I have hopes of getting out one day....Nowadays, I want to do good, no more wrong.” (Study 4).

Recognising the many variations of this theme from the participants highlights it as a salient topic, relevant to identity.

Personal Meaning

Studies in the review reported different ways in which personal meaning was gained. All studies acknowledged a loss of opportunity and a sense of waiting from the participant accounts. Much of this was linked to the idea that punishment and restriction was a part of this experience. However, this punishment took two different forms in the studies – some participants spoke of remorse:

“I’ve understood that everything gets paid for, there is the law and that is normal. So if you understand that, you can live in peace and change course. There are regrets; remorse restores my energy.” (Study 4)

For others it was a continual thing that they could not escape:

“The suffering is every morning, because I have nothing to do with my days. It’s everyday the same....Suffering is the anxiety every morning of the day to come.” (Study 4)

Related to this quotation is the notion of waiting. The participants do not explicitly define what they are waiting for, but all studies, except study 6, allude to this concept. It is thought that this may be related to the context of serving a prison sentence or being legally detained, but this link seems tenuous, when the notion of ‘getting out’ is rarely mentioned across the studies. This is an area which requires further research.

Only two studies (1, 3) reported on the importance of meaningful work to engage with. In these two studies, participants felt that the skills they had were important for them and had difficulty in understanding the therapeutic rationale for things they saw as ‘games’ or ‘therapy’:

“I used to make security fences for the place, then I was on the paint party to decorating the place, then the projects renovating the wards – and they wanted me to do fuzzy felt pictures.” (Study 1)

It appeared that the therapeutic interventions were not something that people could gain self-esteem from especially when compared to occupational activities.

Relationships

The use of the term ‘relationship’ refers to the many different relationships which were referred to within the studies, such as with staff, peers, the ‘outside world’ and the environment which participants were a part of. The relationships within the participants’ environment with staff and peers appeared to be polarised, with some people finding these relationships to be threatening and controlling (study 1, 2, 4, 5) and others finding them a source of support (study 3, 4). Considering the highly controlled environment that the participants are a part of, the polarity in relationships does not appear surprising, as it is

hypothesised that people are either seen as allies or enemies when considering the themes of power and risk alongside this finding.

In this theme there also appeared to be the relationships with families which were mentioned in studies 3 and 4. This was highlighted with the idea of trying to be a part of something to which individuals may not feel a part of:

“I’m a little afraid to be a couple again...on the whole there has been progress, but I still have anxieties about being released to the outside.” (Study 4)

“Family contact dwindles away for those who have been in hospital for a long time.” (Study 3)

This theme does however highlight a narrative different from that of ‘mad’ or ‘bad’, and was one of the only elements in the studies that referred to another part of the lives of participants involved in the studies. Despite feeling removed from the relationships with their families, it demonstrated that some people had other meaningful relationships outside their current existence.

Discussion

This synthesis supports the idea that the experience of mental health problems whilst in the criminal justice system is a complex and difficult experience which requires further investigation. The themes of Systems, Identity, Personal Meaning and Relationships appear to be closely intertwined and have a combined impact on the experiences of people. Interestingly these themes give a further overview of how personal, societal and structural factors link together to shape experience.

The personal factors relate to the participants’ own experiences and beliefs about their situation as well as how these prior experiences are shaping their current perceptions. The societal factors refer to the political and legal aspects which have to be considered to put a person’s experience into context. In this factor, it is also worth considering the general views of society which is shaped by the language of the time. The structural factors relate to the organisational aspects of the environment. Often these are shaped by the political and legal aspects, but also take into account the economic climate, government policy and the resources available. Together these factors shape the experiences of each individual.

Considering these different factors along with the findings from the synthesis has offered some insight into the experiences beyond that of quantitative studies. One thing that it highlights is the power of language to shape identity in the system in which people live. The strong presence of the systems and organisational structure that a person is a part of appears to shape their experience. However, if this is the case, it would be thought that there would be equal emphasis on both mental health and criminal justice issues. Yet the review highlights that the system most spoken about was the legal system. The reference to mental health problems was implicit in areas such as risk and threat, but it must be noted that reference to this is part of the review was limited. This may be due to the fact that people who were deemed 'too unwell' did not take part in these studies, but this is only a supposition.

Across all themes, it was noted how the language of the systems the shaped the participants' identities. If this is the case, then it may be important to change of the language used in these settings in order to allow people to construct identities other than 'mad or 'bad'. The use of 'patient' in study 3 shows that this is a possibility and perhaps suggests a way in which identities can be adjusted.

Although this review highlights some insight into peoples' experience, it does not appear to capture the whole picture. In highlighting some salient themes, it has also opened up questions to how do the systems, identity and relationships shape personal experiences at a deeper level?

Having discussed the areas highlighted by the review, it is also important to consider the limitations. The small numbers of papers included in this review may have affected the findings. Larger numbers may have resulted in a richer understanding of the themes presented. The thematic synthesis was performed by one researcher, which may have led the findings to be more open to bias and subjective interpretation. This could have been reduced by using triangulation with multiple reviewers. As international studies were included in this review, the differing systems of the countries may have led to differences in experiences. Limiting the search to UK papers would have ensured that people's experiences were captured from similar systemic influences. Finally, it should also be mentioned that the findings of study 5 proved difficult to incorporate. This was because the study did not provide any direct quotations

from the participants. This meant the link between the 10 themes identified and the interview data was not transparent and had to be taken at face value, which gave little room for interpretation into the descriptive themes.

Despite these limitations, the review highlights a need to better understand the experiences of those within the criminal justice system in order to be able to provide relevant support and treatment. The review indicates that subjective perceptions of Identity, Relationships and Personal Meaning need to be addressed within the framework of the organisational structure.

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Appendix A: Search terms used for electronic databases PsychINFO (1806 - August Week 2 2011)

1	prisoners.mp. or exp Prisoners/	11282
2	prison.mp. or exp Prisons/	11213
3	Incarceration.mp. or exp Incarceration/	4461
4	exp Criminals/ or exp Mentally ill Offenders/ or offender*.mp	27863
5	exp Mental Health/ or exp Mental Disorders/ or exp "Mental Illness (Attitudes Toward)"/ or mental health problem*.mp.	400962
6	exp Psychological Needs/ or psychological.mp.	253024
7	experience*.mp.	374598
8	exp Self Perception/ or exp Perception/ or perception*.mp.	375923
9	exp Narratives/ or narrative*.mp.	31885
10	exp Qualitative Research/ or exp Interviews/ or qualitative*.mp.	82707
11	exp Phenomenology/ or phenomenology*.mp.	12330
12	grounded theory.mp. or exp Grounded Theory/	6770
13	exp Content Analysis/ or thematic analysis.mp.	10479
14	mixed method*.mp.	4756
15	1 or 2 or 3 or 4	41401
16	5 or 6	612901
17	7 or 8 or 9	717976
18	10 or 11 or 12 or 13 or 14	107895
19	15 and 16 and 17 and 18	142

Medline (R) (1948 – August Week 2 2011)

1	Prisoners/ or Prisons/ or Prison*.mp.	18070
2	incarceration.mp.	4461
3	offend*.mp.	25191
4	offender.mp. or Criminals/	14740
5	mentally ill offender*.mp.	2932
6	Mental Disorders/ or mental health problem*.mp. or Mental Health/	84546
7	psycholog*.mp.	481288

8	experience*.mp.	374598
9	perception*.mp. or Perception/	310590
10	Narrative*.mp.	31885
11	qualitative*.mp. or Interviews as Topic/ or Qualitative Research/	73701
12	phenomenology.mp.	12328
13	grounded theory*.mp.	6773
14	content analysis.mp.	12431
15	thematic analysis*.mp.	2116
16	mixed method*.mp.	4756
17	1 or 2 or 3 or 4 or 5	43543
18	6 or 7	544121
19	8 or 9 or 10	657793
20	11 or 12 or 13 or 14 or 15 or 16	100789
21	17 and 18 and 19 and 20	156

EMBASE (1980-2011 Week 32)

1	prisoner/ or prison/ or prisoner*.mp.	11787
2	incarcerat*.mp.	7380
3	offender/ or offend*.mp.	25191
4	criminal*.mp. or criminal behavior/	36806
5	mentally ill offender*.mp.	2932
6	mental health/ or mental health problem*.mp.	34816
7	mental*.mp. or attitude to mental illness/ or mental patient/ or mental disease/ or mental stress/ or mental health/	344069
8	psycholog*.mp. or psychology/	481288
9	experience*.mp. or experience/ or personal experience/	374598
10	perception*.mp. or perception/	310590
11	narrative/ or narrative*.mp.	31885
12	qualitative*.mp. or qualitative analysis/ or qualitative research/	73701

13	phenomenology/ or phenomenolog*.mp.	21991
14	interview/ or grounded theory/ or semi structured interview/ or grounded theor*.mp.	6872
15	thematic analysis/ or thematic analys*.mp.	2238
16	mixed method*.mp.	4756
17	1 or 2 or 3 or 4 or 5	59107
18	6 or 7 or 8	750066
19	9 or 10 or 11	657793
20	12 or 13 or 14 or 15 or 16	98967
21	17 and 18 and 19 and 20	267

Appendix B: Critical Appraisal Tool (London Cabinet Office 2003)

		a) Appraisal questions	b) Quality indicators (possible features for consideration)	c) notes on study being appraised
FINDINGS	1	How credible are the findings?	<p>Findings/conclusions are supported by data/study evidence (i.e. the reader can see how the researcher arrived at his/her conclusions; the 'building blocks' of analysis and interpretation are evident)</p> <p>Findings/conclusions 'make sense'/have a coherent logic</p> <p>Findings/conclusions are resonant with other knowledge and experience (this might include peer or member review)</p> <p>Use of corroborating evidence to support or refine findings (i.e. other data sources have been used to examine phenomena; other research evidence has been evaluated: see also Q14)</p>	
FINDINGS	2	How has knowledge/ understanding been extended by the research?	<p>Literature review (where appropriate) summarising knowledge to date/key issues raised by previous research</p> <p>Aims and design of study set in the context of existing knowledge/ understanding; identifies new areas for investigation (for example, in relation to policy/practice/substantive theory)</p> <p>Credible/clear discussion of how findings have contributed to knowledge and understanding (e.g. of the policy, programme or theory being reviewed); might be applied to new policy developments, practice or theory</p> <p>Findings presented or conceptualised in a way that offers new insights/alternative ways of thinking</p> <p>Discussion of limitations of evidence and what remains unknown/unclear or what further information/research is needed</p>	

FINDINGS	3	How well does the evaluation address its original aims and purpose?	<p>Clear statement of study aims and objectives; reasons for any changes in objectives</p> <p>Findings clearly linked to the purposes of the study – and to the initiative or policy being studied</p> <p>Summary or conclusions directed towards aims of study</p> <p>Discussion of limitations of study in meeting aims (e.g. are there limitations because of restricted access to study settings or participants, gaps in the sample coverage, missed or unresolved areas of questioning; incomplete analysis; time constraints?)</p>	
FINDINGS	4	Scope for drawing wider inference – how well is this explained?	<p>Discussion of what can be generalised to wider population from which sample is drawn/case selection has been made</p> <p>Detailed description of the contexts in which the study was conducted to allow applicability to other settings/contextual generalities to be assessed</p> <p>Discussion of how hypotheses/propositions/findings may relate to wider theory; consideration of rival explanations</p> <p>Evidence supplied to support claims for wider inference (either from study or from corroborating sources)</p> <p>Discussion of limitations on drawing wider inference (e.g. re-examination of sample and any missing constituencies: analysis of restrictions of study settings for drawing wider inference)</p>	
FINDINGS	5	How clear is the basis of evaluative appraisal?	<p>Discussion of how assessments of effectiveness/evaluative judgements have been reached (i.e. whose judgements are they and on what basis have they been reached?)</p> <p>Description of any formalised appraisal criteria used, when generated and how and by whom they have been applied</p> <p>Discussion of the nature and source of any divergence in evaluative appraisals</p> <p>Discussion of any unintended consequences of intervention, their impact and why they arose</p>	

DESIGN	6	How defensible is the research design?	<p>Discussion of how overall research strategy was designed to meet aims of study</p> <p>Discussion of rationale for study design Convincing argument for different features of research design (e.g. reasons given for different components or stages of research; purpose of particular methods or data sources, multiple methods, time frames etc.)</p> <p>Use of different features of design/data sources evident in findings presented</p> <p>Discussion of limitations of research design and their implications for the study evidence</p>	
SAMPLE	7	How well defended is the sample design/ target selection of cases/documents?	<p>Description of study locations/areas and how and why chosen</p> <p>Description of population of interest and how sample selection relates to it (e.g. typical, extreme case, diverse constituencies etc.)</p> <p>Rationale for basis of selection of target sample/settings/documents (e.g. characteristics/features of target sample/settings/documents, basis for inclusions and exclusions, discussion of sample size/number of cases/setting selected etc.)</p> <p>Discussion of how sample/selections allowed required comparisons to be made</p>	
SAMPLE	8	Sample composition/case inclusion – how well is the eventual coverage described?	<p>Detailed profile of achieved sample/case coverage</p> <p>Maximising inclusion (<i>e.g. language matching or translation; specialised recruitment; organised transport for group attendance</i>)</p> <p>Discussion of any missing coverage in achieved samples/cases and implications for study evidence (<i>e.g. through comparison of target and achieved samples, comparison with population etc.</i>)</p> <p>Documentation of reasons for non-participation among sample approached/non-inclusion of selected cases/documents</p> <p>Discussion of access and methods of approach and how these might have affected participation/coverage</p>	

DATA COLLECTION	9	How well was the data collection carried out?	<p>Discussion of:</p> <ul style="list-style-type: none"> • who conducted data collection • procedures/documents used for collection/recording • checks on origin/status/authorship of documents <p>Audio or video recording of interviews/discussions/conversations (if not recorded, were justifiable reasons given?)</p> <p>Description of conventions for taking fieldnotes (e.g. to identify what form of observations were required/to distinguish description from researcher commentary/analysis)</p> <p>Discussion of how fieldwork methods or settings may have influenced data collected</p> <p>Demonstration, through portrayal and use of data, that depth, detail and richness were achieved in collection</p>	
ANALYSIS	10	How well has the approach to, and formulation of, the analysis been conveyed?	<p>Description of form of original data (e.g. use of verbatim transcripts, observation or interview notes, documents, etc.)</p> <p>Clear rationale for choice of data management method/tool/package</p> <p>Evidence of how descriptive analytic categories, classes, labels etc. have been generated and used (i.e. either through explicit discussion or portrayal in the commentary)</p> <p>Discussion, with examples, of how any constructed analytic concepts/typologies etc. have been devised and applied</p>	
ANALYSIS	11	Contexts of data sources – how well are they retained and portrayed?	<p>Description of background or historical developments and social/organisational characteristics of study sites or settings</p> <p>Participants' perspectives/observations placed in personal context (e.g. use of case studies/vignettes/individual profiles, textual extracts annotated with details of contributors)</p> <p>Explanation of origins/history of written documents</p> <p>Use of data management methods that preserve context (i.e. facilitate within case description and analysis)</p>	

ANALYSIS	12	How well has diversity of perspective and content been explored?	<p>Discussion of contribution of sample design/ case selection in generating diversity Description and illumination of diversity/multiple perspectives/alternative positions in the evidence displayed</p> <p>Evidence of attention to negative cases, outliers or exceptions</p> <p>Typologies/models of variation derived and discussed</p> <p>Examination of origins/influences on opposing or differing positions</p> <p>Identification of patterns of association/linkages with divergent positions/groups</p>	
ANALYSIS	13	How well has detail, depth and complexity (i.e. richness) of the data been conveyed?	<p>Use and exploration of contributors' terms, concepts and meanings</p> <p>Unpacking and portrayal of nuance/subtlety/intricacy within data</p> <p>Discussion of explicit and implicit Explanations</p> <p>Detection of underlying factors/influences</p> <p>Identification and discussion of patterns of association/conceptual linkages within data</p> <p>Presentation of illuminating textual extracts/observations</p>	
REPORTING	14	How clear are the links between data, interpretation and conclusions – i.e. how well can the route to any conclusions be seen?	<p>Clear conceptual links between analytic commentary and presentations of original data (<i>i.e. commentary and cited data relate; there is an analytic context to cited data, not simply repeated description</i>)</p> <p>Discussion of how/why particular interpretation/significance is assigned to specific aspects of data – with illustrative extracts of original data</p> <p>Discussion of how explanations/ theories/conclusions were derived – and how they relate to interpretations and content of original data (<i>i.e. how warranted</i>); whether alternative explanations explored</p> <p>Display of negative cases and how they lie outside main proposition/theory/ hypothesis etc.; or how proposition etc. revised to include them</p>	

REPORTING	15	How clear and coherent is the reporting?	<p>Demonstrates link to aims of study/research questions</p> <p>Provides a narrative/story or clearly constructed thematic account</p> <p>Has structure and signposting that usefully guide reader through the commentary</p> <p>Provides accessible information for intended target audience(s)</p> <p>Key messages highlighted or summarized</p>	
REFLECTIVITY NEUTRALITY	16	How clear are the assumptions/theoretical perspectives/values that have shaped the form and output of the evaluation?	<p>Discussion/evidence of the main assumptions/hypotheses/theoretical ideas on which the evaluation was based and how these affected the form, coverage or output of the evaluation (<i>the assumption here is that no research is undertaken without some underlying assumptions or theoretical ideas</i>)</p> <p>Discussion/evidence of the ideological perspectives/values/philosophies of research team and their impact on the methodological or substantive content of the evaluation (<i>again, may not be explicitly stated</i>)</p> <p>Evidence of openness to new/alternative ways of viewing subject/theories/assumptions (<i>e.g. discussion of learning/concepts/ constructions that have emerged from the data; refinement restatement of hypotheses/theories in light of emergent findings; evidence that alternative claims have been examined</i>)</p> <p>Discussion of how error or bias may have arisen in design/data collection/analysis and how addressed, if at all</p> <p>Reflections on the impact of the researcher on the research process</p>	

ETHICS	17	What evidence is there of attention to ethical issues?	<p>Evidence of thoughtfulness/sensitivity about research contexts and participants</p> <p>Documentation of how research was presented in study settings/to participants <i>(including, where relevant, any possible consequences of taking part)</i></p> <p>Documentation of consent procedures and information provided to participants</p> <p>Discussion of confidentiality of data and procedures for protecting</p> <p>Discussion of how anonymity of participants/sources was protected</p> <p>Discussion of any measures to offer information/advice/services etc. at end of study <i>(i.e. where participation exposed the need for these)</i></p> <p>Discussion of potential harm or difficulty through participation, and how avoided</p>	
AUDIBILITY	18	How adequately has the research process been documented?	<p>Discussion of strengths and weaknesses of data sources and methods</p> <p>Documentation of changes made to design and reasons; implications for study coverage</p> <p>Documentation and reasons for changes in sample coverage/data collection/analytic approach; implications</p> <p>Reproduction of main study documents <i>(e.g. letters of approach, topic guides, observation templates, data management frameworks etc.)</i></p>	

Journal Paper

“I’ll Be Very Dangerous Until Somebody Decides I’m Not.” The Experience of Transfer from Prison to High Secure Hospital: A Thematic Analysis*

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Abstract

Background: In the UK there are numerous sentenced men who are diverted from the criminal justice system to secure hospitals under the Mental Health Act. For some, detainment remains without limit and continues over their original sentence length. To date no research exists exploring the experience of transfer.

Aim: The aim of this study was to document this journey from prison to high secure hospital and explore participants' understanding of their position.

Method: Purposeful sampling was used to recruit 11 participants from a high secure hospital in England. Thematic analysis was used to analyse the data.

Results: Four main themes emerged from the interviews: *Shifting Identities*, *Understanding and Negotiating*, *Engaging with Therapy*, and *Making Sense of Time*. These were constructed into a thematic map.

In the paper we concentrate on the two of the four themes derived from the interviews: *Shifting Identities* and *Understanding and Negotiating* to provide a detailed description and discussion of these themes.

Conclusion: The results of this study suggest that transfer from prison to high secure hospital for men signifies a transition that strongly influences their social identity. This is strongly influenced by the participants' understanding of the existing processes of treatment and rehabilitation which exist in the high secure hospital. The study highlights a need for psychological treatment to be more focussed on the meaning of transfer, diagnosis and identity in order to facilitate adjustment to the process of treatment and rehabilitation in this setting.

Introduction

Historically societies have attempted to contain those who deviated from accepted standards of behaviour. Concrete examples of this are the imprisonment of those who infringe the law and confinement in asylums of those who display unusual thoughts and behaviours, behaviours that are now understood as resulting from mental health difficulties. Consideration has been given in recent times to the 'institutionalising' practices of history. (Bauduin, McCulloch & Liegeois, 2002) and reforms in the prison system allow for the monitoring of people through community arrangements (Lanning, Loader & Muir 2011). This has meant the closure of asylums. Even though the configuration of these institutions have developed and changed, with some even abandoned in concrete form, the social processes which create them still exist. Institutions arise from human interaction, which both constructs and is constructed by individuals. They develop from shared values, culture and social practices, and exist within a complex array of power relationships (Foucault, 1979; Giddens, 1979). *[See section 1.1 for further discussion: Institutionalising Practices of History and See section 1.2 for further discussion: The Role of Power]*

Criminal Justice vs Healthcare

In the UK there are two well established systems which serve contrasting functions. The criminal justice system (CJS) maintains a focus on punishment, security and control whilst the healthcare system has an emphasis on welfare and care (Knight and Stephens, 2009; Laing, 1999; The Sainsbury Centre for Mental Health, 2006). Despite the contrast in ideologies both systems share the ability to withhold a person's liberty, if required, through prison sentence or the Mental Health Act (MHA). Both the symbolic and bureaucratic expression of these systems are embodied in the bricks and mortar of institutions such as prisons and hospitals.

Deprivation of liberty has continued to be an internationally recognised means of punishing offenders (Goffman, 1961; Sykes, 1958). Seen as a socially acceptable alternative to corporal punishment it is a means to punish through penitence, retribution and deterrence with the main distress to the offender

caused by a lack of liberty (Foucault, 1979). For most offenders this incarceration is predetermined and finite.

In the UK services to support and manage people experiencing mental health difficulties which deliver treatment and care are predominantly provided by the National Health Service (NHS). Attention should be drawn to the fact that, since the turn of the 19th century, these care services have operated within the backdrop of mental health law which make it difficult to provide wholly patient-centred care (Vassilev & Pilgrim, 2007). Pilgrim (2007) argues the institutionalising responses to mental health issues through the construction of an asylum based system have fundamentally changed the landscape. This suggests that these large institutions served three major functions: 'residency (to warehouse chronicity); risk containment (to provide social control on behalf of a moral order); and reducing symptoms (to treat acute episodes)' (p.541). The impact of institutions on those who live in them was rarely considered until Goffman's seminal work, *Asylums*, (1961). In this Goffman defined 'Total Institutions' as places which were all encompassing of daily activities and where people who share similar social situations are cut off from wider society. It could be argued that secure hospitals in the UK intersect the boundaries between the CJS and mental health system and occupy both the concrete and the conceptual framework described by Goffman. Inhabiting these twin realms of control and treatment presents tensions for both the detained and those responsible for the psychological care, rehabilitation and containment of offenders in this system. *[See section 1.3 for further discussion: Total Institutions]*

Offenders, Deviants or Patients?

The dilemmas facing clinicians in balancing considerations of risk management and treatment become magnified when contemplating the treatment of offenders with mental health problems. They fall within the contrasting ideologies of the criminal justice and health systems (Laing, 1999), and the heart of the debate remains the 'to care' or 'to punish' dichotomy (Maden, 2007). *[See section 1.4 for further discussion: Criminal Justice versus Healthcare]*

At present UK law is required to emphasise and protect individual rights as it incorporates international human rights legislation. Current legislation suggests that society is justified in protecting itself by holding a person in custody for a period proportionate to the severity of the offence, but should do all that it can to offer treatment and rehabilitate the individual (Gostin, 1977). These ideals appear profoundly disparate and have led ethicists to voice concerns about balancing the rights of the 'unwell' individual against those of the general public (Maden, 2007). [See section 1.5 for further discussion: *Human Rights and Mental Health Law*]

Current UK policy aims to 'divert' offenders with mental health problems or learning disabilities (DoH, 2009; MoJ, 2010) away from the criminal justice system to forensic mental health services at the earliest opportunity. The transfer allows for a person's criminal status to become secondary to their primary need for hospital treatment. Once diverted a person's liberty is controlled by the conditions of the treatment order received. Under the MHA the offender's original sentence, once admitted to forensic services, becomes irrelevant. The original sentence only remains valid if treatment ends before the full sentence is served. In these cases the individual would be returned to prison to serve the remainder of their time (MoJ, 2010). For people with a prison sentence transferred to forensic services the conditions of their stay are altered from a discrete length of detention to an indeterminate period under 'notional hospital orders'. Treatment of an individual is only considered 'complete' when they are deemed 'well' and are considered sufficiently rehabilitated for a return to wider society. The final decision about leaving the secure hospital is reliant upon the judgement of others such as the Responsible Clinician and / or the Secretary of State for Justice (MoJ, 2010). The exact number of people who have been detained beyond the limits of their original sentence for treatment purposes is unknown. Published figures from the Ministry of Justice or Department of Health do not highlight those individuals who are still receiving treatment¹. It is this group that is the focus of this study.

¹ For the purposes of this study, this will be referred to as an 'indeterminate sentence'. (It should be noted that this term does not refer to the indeterminate sentences for people Imprisoned for Public Protection, IPP).

Challenges to Rehabilitation

The transfer of offenders with mental health difficulties to forensic services has become part of UK policy and service provision (DoH, 2009; MoJ, 2010). The vast majority of people transferred from prison or the courts initially enter high or medium secure facilities (MoJ; 2010). There are currently nearly 4,500 secure places (beds) in high and medium secure forensic services and all high secure beds are provided by the NHS.

The duality of the context combined with the multiple roles inhabited by professionals, delivering both care and risk management, highlights the juxtapositions, practical and ethical, for both the detained and the professionals providing treatment (Adshead, 2014; Ward, 2013). Detained individuals may have to contend with a complex and shifting nature that engagement with services naturally brings, which finds individuals inhabiting the roles of detained patient, with an emphasis on promoting wellbeing, as well as dangerous offender, with a need to reduce risk. This dichotomy is amplified in a context where staff may be struggling to incorporate the disparate philosophies of the overarching systems into day-to-day care (Adshead & Sarkar, 2005). It could be reasoned that these complexities could be further compounded when faced with an indeterminate sentence due to treatment considerations.

Effective rehabilitation for this population should, in theory, allow for integration back to society. Professionals working within forensic settings need to balance treatment goals with offence focussed work. These should address the reduction and management of the risk of criminal behaviour and also support individuals to manage the distress of complex mental health problems (Ferguson, Conway, Endersby, & MacLeod, 2009). In order to accommodate these goals treatments are rooted in a multidisciplinary team (MDT) approach, with clinical psychology providing key components.

In recent years there has been a push towards patient-centred mental health care (DoH, 2011). Research has indicated that involving patients in care processes which are enhanced by positive engagement and therapeutic alliance, either in terms of the quality of relationship or mutually agreed aims, improves outcomes (Sidani, 2008; Wampold, 2013). In a forensic environment delivering patient-centred care faces several challenges which creates serious

problems in providing therapy which is truly inclusive, collaborative and able to promote equality (Green, Batson, & Gudjonsson, 2011). Providing required rehabilitation and treatment to an individual that encourages engagement and facilitates power sharing is complicated by the context of an involuntary and indeterminate sentence (Livingston, Nijdam-Jones, Brink, 2012). Furthermore, evidence suggests that in some instances mandatory treatment in custodial settings appears ineffective whereas voluntary treatment produces significantly better outcomes (Parhar, Wormith, Derkzen, & Beauregard, 2008). That is not to say that genuine and supportive relationships cannot be created in this context. However, as the inference is that positive engagement in therapy can have a direct influence on release, it is questionable whether engagement can be truly voluntary. This scenario is further complicated by a duty of forensic services to protect the public from harm whilst also evaluating risk posed by those detained. This fundamentally cements the professionals' role as custodian (Ward, 2013). [See section 1.7 for further discussion: *Patient-Centred Mental Healthcare* and section 1.8 *The Context of the High Secure Hospital*]

The environment of a secure hospital requires both clinicians and those detained to feel safe. A comprehensive and integrated approach to safety and security is therefore adopted. These mechanisms of security, although promote safety, often limit liberty. There has been a wide variety of research documenting the negative psychological effects of detention in the prison population (Haney, 2003; 2012). The literature identifies the main stressors as the loss of liberty, autonomy, security, relationships, and goods and services (Sykes, 1958). There has been no research to-date examining the psychological effects and experience of transfer and indeterminate detention for rehabilitation of prisoners in forensic services. Therapy often focuses upon improving wellbeing through promoting self-acceptance, positive relations with others, autonomy, environmental mastery, purpose in life and personal growth (Ryff, 1989). The extent to which this can be achieved in both the physical environment and ethos of secure hospitals, therefore, needs further interrogation. [See section 1.6 for further discussion: *Psychological Impact of Detention* and section 1.9 for further discussion: *Time Perspectives*]

The Current Study

Recent UK policy aims to 'divert' offenders experiencing mental health problems away from the criminal justice system to health services at the earliest opportunity. Those transferred under the MHA to secure hospitals will experience a change in the status of their sentence from a finite time to until they are deemed 'well enough' and 'safe enough' to be released. For those deemed the most dangerous and the most 'unwell', their treatment in secure services may be longer than the length of their original sentence and the length of their detention in an institution will have no definite release date.

This study is in response to the gap in qualitative literature exploring the experiences of men detained in forensic mental health services and how they perceive rehabilitation and other aspects of their care (Coffey, 2006). This study is designed to capture individual perspectives in an attempt to build an understanding of the subjective, salient issues for men transferred from the prison system to mental health services. It attempts to understand individuals' conceptualisation of their situation given their transfer from prison (and the criminal justice system) and being detained indeterminately in mental health services, under the MHA, for treatment and rehabilitation. These findings are central in understanding how those transferred make sense of their situation and can be used to inform current intervention planning and service development. Guidance on relevant issues influencing individual psychological responses to the environment can help shape the role of clinical psychology in this field, (See Appendix H for Conceptualisation of Research).

Research Methodology

Design

We employed a qualitative design using semi-structured interviews to explore how participants' experienced their transfer and being detained indefinitely for treatment and rehabilitation. *[See section 2.1 for further discussion: Rationale for Qualitative Methods]* Semi-structured interviews were felt to be useful in allowing the participant to share their experience. *[See section 2.2 for further discussion: Conducting interviews]*. This method also allows the researcher to incorporate participants' language and concepts whilst encouraging participants to express otherwise implicit assumptions and thus generate novel insights in relation to the research question (Willig, 2001). Following transcription of the interviews thematic analysis (TA) was conducted to identify patterns, analyse and report themes within the data (Braun & Clarke, 2006). We chose this method over others (such as Interpretative Phenomenological Analysis) due to the atheoretical stance that TA facilitates in the analysis of data (see below). *[See section 2.3 for further discussion: Thematic Analysis]*.

Procedure

Ethical approval was received from the University of Lincoln, Nottingham Research Ethics Committee and relevant NHS Research and Development departments. *[See section 2.4 for further discussion: Ethical Considerations]*. Participants were recruited using purposive sampling from a single high secure hospital in England from either the mental health or personality disorder directorates (n=206). *[See section 2.5 for further discussion: Sampling]*. Men were eligible to participate if they were aged 18 and above, had been transferred from prison service under detention of the Mental Health Act (MHA), and had overstayed their original sentence length for treatment purposes. Potential participants, initially, were identified using hospital records (n=32) identifying them only by the MHA section they were transferred with and patient number. Once identified, permission was sought from Responsible Clinicians to approach participants who they deemed well enough to be included in the study (n=27). Information about the study was then sent to these participants. *[See section 2.6 for further discussion: Procedure]*.

A total of twelve men agreed to participate. Interviews took place on the home ward of each participant and were facilitated by the first author (SG). In total eleven men were interviewed (one interview was cancelled as the participant was deemed to be too unwell on the day the interview was scheduled). To protect the anonymity of the participants only limited demographic characteristics can be offered here. Pseudonyms are used throughout.

Table 4: Information about the Participants

Name	Age	Ethnicity	Number of years detained in high secure hospital	Primary diagnosis of mental health (MH) or personality disorder (PD)
Adrian	45	White British	8	PD
Ben	44	White British	3	PD
Mark	59	White British	6	PD
James	40	White British	10	PD
Paul	52	White British	6	PD
Sam	53	White British	11	PD
Chris	39	White British	4	PD
Joe	30	White British	6	MH
Shaun	34	White British	8	MH
Steve	40	White British	4	MH
Ed	47	White British	4	MH

Interviews were digitally recorded and transcribed verbatim by SG or a professional transcriber and anonymised to ensure confidentiality.

Data Analysis

Social constructionism was the epistemological framework that underpinned this study and, by extension, the analysis. Thematic analysis was conducted based on the six-stage process outlined by Braun and Clarke (2006). An inductive approach was used and themes identified were initially semantic, linked to the data collected and not informed by a pre-existing framework. A second level of analysis involved discussion of initial codes with the second author (RdN) which facilitated a latent-level analysis. This led to the generation of subthemes and themes. Themes were then organised into a final thematic map showing the themes and subthemes and interactions between them (Appendix A). *[See section 2.7 for further discussion: Analysis; section 2.8 for further discussion: Epistemology; Section 2.9 for further discussion: Upholding Quality].*

Results

Four main themes emerged with some consisting of smaller subthemes: *Shifting Identities*, *Understanding and Negotiating*, *Engaging with Therapy*, and *Making Sense of Time*. These were constructed into a thematic map.

The themes constructed from the data highlighted the participants' experiences as a number of linked dynamic processes between understanding various Systems², within the context of a journey, situated in the overarching framework of 'time'. In order to report the themes they are categorised separately; however, as shown by the thematic map, the themes are closely linked and often overlap.

In this paper we concentrate on the two themes *Shifting Identities* and *Understanding and Negotiating* to provide a detailed description and discussion. We felt that these two themes best captured the participants' experiences of being transferred from prison to the secure hospital and how they understood their position within this environment. [See section 3.1 for further discussion: *Engaging with Therapy* and section 3.2 for further discussion: *Making Sense of Time*].

Shifting Identities

This theme represents how participants described a shift in identity on entering the secure hospital. It outlines individual experiences as well as noting how these identities are influenced by wider Systems in which the secure hospital is situated. The theme discusses the perceived ebb and flow of different identities for participants.

Throughout their accounts the language of psychiatry becomes more evident and the adoption of constructs of illness and madness³ are apparent. All participants made reference to either their psychiatric diagnoses or the

² Throughout their interviews participants in this study referred to various 'systems'. In order to clarify and understand the results the use of "System" will refer to broader systems (such as social care, the criminal justice system, the healthcare system, the education system etc), whilst the use of "system" will refer to the high secure hospital.

³ We use the terms 'mad' and 'madness' to reflect both our participants' language and our social constructionist perspective of the term, and it's association with works of poststructuralist scholars such as Foucault, Derrida, and Chesler.

directorate they were assigned to, despite the fact that this was never a focus during the interviews. This reflects the overtly medicalised discourses surrounding individual distress which appears to be embedded in the traditional psychiatric models of institutional culture:

Joe/44⁴: Some doctors are saying it could be schizophrenia, some doctors are saying it could be schizoaffective disorder because what happened was I went to mental health side first to be assessed for mental illness to see what it was and like I was saying I wasn't ill, but I was ill, so that I could get out, do you know what I mean, so what happened was I had a tribunal and they said that they agreed that I wasn't ill, so I got reclassified and they said I was antisocial, but when they said antisocial they said I can be reassessed for personality disorder, so I went to the personality disorder directorate for an assessment and they diagnosed me as really antisocial for being in jail ten times and then I was called backwards and forwards

Joe's description indicates that he is being acted upon by the system with little collaboration suggesting his powerlessness in the process. The distinction here, posed by others ('doctors', 'tribunals') between being 'ill' ('schizophrenia', 'schizoaffective') versus not ill (being 'reclassified' as 'antisocial') also marks these shifts for the individual. Regardless of the perceived lack of collaboration, however, some indicated that labelling their mental health difficulties through the use of psychiatric diagnoses helped their subjective understanding of their experience:

James/14: Well at least I've got something, I feel I can understand now

For James the very process of having 'something' appears to have added value for his own personal meaning. Interestingly, although there was a dominance of medical terms in the accounts, James does not label the actual medical diagnosis, naming it simply as 'something'. For others being ascribed an illness identity appeared to reflect subjective embodied experiences of having a mental health problem. For example Ben identified that he felt like '*a different person when I'm unwell*' (/130).

These experiences of diagnoses were not necessarily reflective of the perceived accuracy of the diagnostic label. Instead most participants

⁴ The numbers after the participant's name denotes the line number for each quotation.

constructed their experiences with language related to overarching concepts of illness and madness, both from psychiatry and lay terms:

Shaun/166: ...they say I'm violent schizophrenic, I don't think I am, but I have got some type of mental illness because when I came off the meds, I went mad.

Here Shaun clearly demonstrates this mix of terms: from schizophrenic, to mental illness, to mad. Others referred to being 'crazy' (Sam), 'nuts' (Joe) and 'ill' (James) to convey their experiences. The above accounts perhaps reinforce the transition for individuals from 'prisoner' to 'patient' as labels of madness were not limited to those within the system but also from the outside. This porous boundary also reflected their shifting identities. For some participants entering the institution imposed an additional transformation in their identity as perceived by the outside world. For Ed the identity of a prisoner was preferable and less stigmatising to that which was attached to being in a secure hospital:

Ed/: The general opinion is that these places are for lunatics....and people that have committed horrific offences...and it's because of that.....that stigma, I would much rather not be here and I would rather be in prison

For others entering the secure hospital signified a powerful change in identity marked by a loss of personhood and possessions. For Mark the processes and practices of crossing the threshold of the institution, and his relationship with it, instantly ('overnight') caused a shift in identity from someone who could responsibly have possessions (such as a 'tin opener') to someone who could not be trusted with such objects (because he has become 'dangerous').

Mark/24: everybody [security and members of the MDT] meeting me at the gate was a bit of a shock to the system; you don't get none of that in prison.....

Interviewer: What did you find difficult about that?

Mark: Just taking all the gear off me, in prison you're allowed tin openers and pocket knives....where here you're not allowed any of that

Interviewer: Ok, how did you feel handing all that stuff over?

Mark: That was the worst bit of it.

Interviewer: ...Can you remember anything you were thinking when you were going through and handing stuff over?

Mark: Well, just how silly it was like, one minute you've got everything and the next minute they're all took off you, it just makes you feel, like dangerous, overnight you've become more dangerous

Whilst participants highlighted the impact of achieving new roles as patients most reflected on the impact detention had on previously valued family roles. Mark and Ed, for example, recognise their absence having a negative impact on their positions as father and brother respectively and perceive the changes as significant losses:

Mark/246: my son, well two sons and a daughter ... they're missing their dad, you know, being locked up and ... all the years go by.

Ed: you have a lot of responsibility towards the younger members of the family, either being a role model ... the problem I've always had is my sister for example, she was only fifteen when I got locked up, so in her eyes I'm mostly just a memory, somebody who was [her] brother

For others maintaining family connections, although a struggle, was recognised as being valuable in their lives.

Mark/34: I've got kids out there who haven't seen me,....before my time's up I want to let them know I do care about them, I do love them

Sam/96 that's all I care about is my brother and making sure he's alright. If I don't get a letter off him for three or four week I get worried

James/162: ...think of the family, one day I'll be there with them.....it keeps me sane.

Understanding and Negotiating the System

All participants described a process of acclimatisation with their environment which is connected to the previous theme. In order to understand and negotiate the system participants felt it was useful to be able to situate themselves in it by defining and redefining their identities. Understanding and Negotiating the system appeared to be an important strategy for participants to manage their time within it.

This theme represents the complexities of the relationship between individuals and the system. Participants articulated a multi-faceted process of building a relationship with the system. This process, whilst idiosyncratic, had a number of shared elements, with participants describing two distinct stages. The first appeared to be constructing the nature of the relationship and understanding the perceived expectations the system places upon individuals (Understanding) in order to then identify a way of negotiating and managing to exist in it (Negotiating).

Understanding

Participants constructed differing personal meanings about their transfer to the secure hospital. They reflected on how the secure hospital is situated in broader contexts, as well as depicting individual experiences of their first encounter with the setting.

All participants constructed their understanding of their transfer to incorporate the wider legal, mental health or care Systems. This was apparent in the accounts of transfer which identify different pathways for entry to this setting and possibly create differing assumptions of what to expect. For example, although some participants recognised the need for punishment implicit in the legal System, they appeared to hold different perceptions of it. James, for instance, recognised it as a fundamentally punitive process:

James/32: I'm not here to make friends or settle down, I'm here to be punished.

Ed, conversely, considered the secure hospital relatively benign in comparison to some alternative places of punishment.

Ed/128: there are some places in the world where people like me, who have committed offences, murder, whatever, don't get a second chance at life, you know

For others the significance of the treatment component at the secure hospital was central to their understanding of their stay. Steve and Mark accepted and adopted the role of being 'patients' to be 'treated' by the System:

Steve/12: I got interviewed by a doctor and he said I've got schizophrenia and I need to get hospital treatment so he recommended I came here [secure hospital].

Mark/12: Well it's just they do more treatment here [secure hospital], where in prison they came to a bit of a halt in treatment they kept promising me treatment but they never put me on it

The occurrence of differing discourses between the participants for their reason for transition suggested distinctive parts of wider Systems influencing their transfer. Whilst this indicates the individuality of the experience of transfer, it also highlights participants' journeys as inextricably linked to the broader contexts of the judicial, mental health and care Systems. Sam and Ben perceived their current situation as a reflection of the failure of multiple Systems throughout their life.

Sam/52: I've been in care... then been dumped onto the streets with no life, no structure, no nothing and then left to our own devices and they wonder why, the System wonders why people go astray; young kids who have no one to turn to, that's the System for you!

Ben/111: ...all these prisons, hospitals, that's all I know because I've been locked up and part of the System since age 13...then they decide they want to help us, because by then it's too late and I'm saying the System has failed people big time.

In addition to the perceived reasons for their transfer the reputation of the secure hospital also appears to have had a powerful impact about what to expect. Paul describes forming assumptions about the secure hospital based on the powerful language used by his treating team:

Paul/18: prior to coming here, a psychiatric nurse in the prison she says to me that me, myself was making a big mistake coming to [secure hospital] and first the prison psychiatrist says to me ... you know he's in for a torrid time, that's the word he used, torrid time, that word torrid doesn't get used very lightly, does it?

All men perceived the power of the system to be pervasive although this was constructed in different ways. For some, institutional regulation was expressed through the experience of constantly being watched or monitored directly or

indirectly. Whilst constant observation is common both in prison and secure hospitals, the additional function of observation in the secure hospital directly influences decisions regarding transitions through the hospital towards release. This is in direct contrast to the experience of being detained in prison where, although people are observed constantly, once an individual has spent their sentence, they will be released. This was reflected in the participants' accounts:

Ed/146: [They]... have eyes and ears everywhere, you know

Joe/424: If they're not watching, they can see us on the camera.

Others identified that the system's power was lodged in its capacity to make potent evaluations about them. The process of observations being recorded in notes and reports appeared to lead to having an identity constructed on paper. This felt like a misrepresentation of their character:

James/290: I'm not a danger to anybody, it's all on paper, I'm very dangerous and that is it, I'll be very dangerous until somebody decides I'm not.

Adrian/68: I had my CPA [Care Programme Approach] a few months ago and my probation officer came...we came in here and had a little chat and she said I can't believe you're the same person I've been reading about.

In James' case he sees two versions of himself: an embodied version constructed by himself (as not dangerous) and a 'paper' version constructed by 'somebody'. It is this version that matters to the system. This distinction between embodied and paper versions is also seen in the surprise articulated by Adrian's probation officer. Perhaps it is because of the discrepancies between these two versions of the self, that a number of participants indicated, despite the level of observation and evaluation, that they felt 'unseen' by the staff and system around them:

Chris/132: although I've spent such a long, long time in these institutions, nobody actually really knows me, they don't know me as a person, as a personality, this is how it seems to me.

Mark: 292: I was expecting when I came here after so many years they would see the proper me...

Once participants had established the nature of the relationship between themselves and the system they embarked on a process of negotiating their way through it.

Negotiating

Participants described various ways of negotiating the system with a sense of complying and submitting to the system to various extents. Central to these accounts was the notion that there was a limit to what could be 'negotiated'. All participants felt that in order to progress through and exit the secure hospital, successful engagement in therapy was a perceived expectation and requirement:

Joe/210: You don't have to do it [therapy], but if you don't do it you can't get out...so really you have to do it.

Ben/25: That's the difference between people who are released and not, doing the therapy work.

Ed/54: if it gets me out of here and if it gets me back to society, if I can be released through doing this, then I'll do it, I'm prepared to do it you know...I'm basically saying to them if you want me to fill in all these forms and so on and certain groups and speak about things, then I'll do it, I'll do it.

Remarkably, only one participant spoke about managing the system by disengaging and not complying:

Shaun/130: I've done a one-to-one and then they tried to say I had to do more of it and I refused and I thought I don't need it anymore, and I refused to do any other courses, they're all a waste of time.

Despite the obligation to be involved in therapy, engagement with the therapies was perceived by most as a meaningful way to make sense of their stay. [This expectation is explored more fully within the theme *Engaging with Therapy* in Extended Results section 3.1]

All participants recognised that inherent to the perceived need to take part in therapy programmes, an additional fixed condition, was the wider expectations

of rehabilitation and treatment influenced by society. This was considered by some in relation to proving their 'risk' had reduced in order to exit the system:

Ed/110: If they're satisfied that I'm no longer a dangerous person and a doctor is satisfied that I'm no longer a dangerous person, then things will start to happen and keys will start to turn

Joe/210: You don't have to do it, but if you don't do it you can't get out because your risk is too high, you haven't minimised your risk.

Having established the critical requirements of the secure hospital most participants presented positive self-narratives. These identified personal characteristics which had supported them in managing their stay in the secure hospital. This was an activity which was identified as requiring a certain level of resilience:

Ed/98: stubbornness, courage, hope, self-belief...just experienced the regime for what it was and tried to get through it, either as a prisoner or as a patient...bit I've managed to keep afloat purely by the fact that I've been physically well and I've had the stamina and strength to cope with all the mental distress....

Ben/102: I just keep going as they say

Although participants perceived personal traits as assets which helped them manage their time in the secure hospital, some also conceded to their inability to change their environment. In order to manage this reality a few participants appeared to negotiate the system by accepting and enduring some aspects of their situation:

Sam/58: I don't agree with everything that goes on in this world, but you have to learn to tolerate this place and the things that go with it because that's all part of moving on.

All participants experienced some parts of the system as supportive which was mostly seen to be through their relationships with staff. Almost all highlighted the fundamental importance of trust, acceptance and staff having time to talk and listen.

Chris/44: trust is crucial for me to talk....Doesn't matter what I've done people in this place don't judge you

Adrian/116: my MDT have been very supportive...and I trust them as well, they've not judged me

Discussion

This study offers unique insights into the experiences of men who are transferred from the prison system to high secure forensic services who remain detained indeterminately for treatment purposes. The presented themes explored men's perceptions of themselves and their relationship with the secure hospital. The themes give an understanding of the intricacies of navigating through the complex and powerful system in which they are situated.

This study goes beyond previous research by revealing what it is like to be transferred from prison and detained indeterminately for treatment and rehabilitation in a high secure hospital. The overarching leitmotif of these interviews was that of 'being a patient', with participants' descriptions of their experiences and the emergent themes largely centred on this. The men also described personal processes that helped them manage and negotiate the system.

'Being a Patient'

Adopting the role of 'patient' by individuals was accentuated by participants mainly through their narratives which emphasised psychiatric and psychological language to describe themselves in terms of diagnosis; the division of the hospital they were allocated to; as well as descriptions of themselves. Only a few made any reference to their crimes, if at all, during the interviews. In the context of this study this process could be viewed through the perspective of social identity theory, which suggests that individuals strive for a positive self-concept (Tajfel & Turner, 1979, 1986). This was demonstrated by participants negotiating the transition from a less valued 'prisoner' identity to one of a more valued 'patient'. This is perhaps not surprising, as people who are diagnosed with severe mental health problems and who have committed offences may be seen to have less personal accountability for their crimes, reducing blame and stigma. This is generally attributed to being 'unwell' due to an untreated or ineffectively treated mental illness. The legal systems in place complement this view by treating individuals with apparent benevolence by diverting individuals away from traditional criminal justice pathways (Pouncey & Lukens, 2010). It has been argued that this understanding of mental 'illness' leans towards a

biomedical model of understanding of mental health problems. This favours biological reductionism and doctor-led treatment decisions (Borrell-Carrio, Suchman & Epstein, 2004; Pouncey & Lukens, 2010). The use of biomedical discourses in this setting could be seen as a powerful tool which facilitates individual adjustment to the role of 'forensic patient' as a more desirable and less culpable identity.

This shift in social identity can be additionally linked to improvements in an individual's ability to manage stigma and help to increase self-esteem (Verhaeghe & Bracke, 2007). This process could be seen as enabling the 'patient' identity as more salient and less stigmatising than that of being a prisoner which has more negative connotations. It is worth noting, however, that the results suggested an inconsistency between participants' self-identification as 'forensic patients' and the perceived stigma associated with being detained in a secure hospital. The paradox of holding this position on stigma has been highlighted in literature with research showing that forensic treatment can take place without impacting on self-stigma whilst simultaneously being exposed to increased levels of social and structural stigma (Livingston, Rossiter, & Verdun-Jones, 2011).

A key consideration in the men's accounts was the degree to which they placed themselves at the centre of their own treatment and rehabilitation. Similar to previous qualitative findings the participants' accounts suggested that they were directed towards the system's notions of rehabilitation. There was little sense of collaboration which may increase their feelings of powerlessness (Mezey et al., 2010). This is a fundamental factor which requires consideration when contemplating effective service delivery for this population. There is an extensive body of literature which emphasises the crucial role of engagement to achieve positive therapeutic outcomes (Wampold, 2013). It is essential, therefore, that an individual should be involved in their treatment goals to experience a sense of control over their lives. Participants' perception of authoritarian practices may reflect the forensic hospital's emphasis on security, containment and supervision, as well as their status as compulsorily detained patients.

Identifying as a 'patient' may also have ramifications for the way in which detained individuals relate to treatment and rehabilitation within the secure hospital. Traditional notions of being a 'patient' suggest the passive role of receiving diagnoses and treatment rather than being actively involved in the process of therapy and rehabilitation. In recent times, in order to address this inconsistency, mental health services have adopted the use of the terms 'client' or 'service user'. This allows for individuals that use services to be identified as consumers anticipated as having choice and an ability to assert autonomy and independence (Crawford *et al.* 2002) Our results, however, suggest that such a change in terminology does not seem to have dented the more traditional view of healthcare practiced by the clinicians and received by the 'patients' (in their own words). Furthermore, the impact of context and the overarching policies and mental health law cannot be disregarded. These directives implement a system which inherently places a dual function on high secure hospitals to take responsibility and 'care' for individuals in a paternalistic manner whilst protecting the community. This position may be best reflected by the use of the term 'patient' by both professionals and those detained whilst simultaneously capturing the mandated position of forensic services.

In contrast to narratives about authoritarian practices was the identification of genuine supportive relationships. Although research has highlighted that trust can be fostered between individuals and in an institution or system (Mechanic, 1998), the trust identified by participants was solely interpersonal and based on human relationships. In line with other conceptualisations of trust in staff-patient relationships participants expressed the value of being able to talk to staff openly and achieving a level of acceptance (Pearson & Raeke, 2000). Trust is recognised as a critical factor for a developing therapeutic alliance (Lambert & Ogles, 2004) and it has been argued that without trust treatment is unfeasible (Rhodes, 2001). There is increasing evidence that creating and maintaining a strong therapeutic relationship can be an agent for change in itself and leads to positive outcomes (Leach, 2005). These relationships, therefore, could be used to promote equality and ameliorate feelings of powerlessness.

Personal Processes

In order to manage their time in the secure hospital the men appeared to adopt a number of coping styles which fell into two general categories of *passive* (compliance and disengagement) and *active* (problem-focused and emotion-focused coping) (Folkman & Lazarus, 1984). Most participants reported using a combination of both styles. The most common passive response was compliance, with participants doing what they believed was expected of them, such as attending therapy programmes. Only one person openly stated that he was choosing not to engage in therapy (disengagement). It appears that by making the decision to comply with the therapy programmes may have given participants a sense of control over their lives and represent a shift to using a problem-focussed coping strategy.

Although participants were aware that there were things they could do to take some control in their lives there were many aspects of the secure hospital which had to be endured. Some talked about suppressing frustrations about aspects of the hospital and hoping that this may make life more bearable and hasten release. This implied using emotion-focused coping strategies such as acceptance which may have reduced their emotional distress. Alternatively this may indicate that some individuals hide emotions that they fear might demonstrate an increased 'risk' and therefore prolong their detainment. This impression management was seen as another form of negotiating the system. *[See section 4.1 for further discussion: Identity; section 4.2 for further discussion: Power and section 4.3 for further discussion: The Position of Therapy].*

Implications for Practice and Policy

Our study has highlighted that the process of being transferred from prison to a high secure hospital for treatment and rehabilitation has a notable impact on individuals. Participants in this study emphasised that the process of transfer to the secure hospital changed their understanding of self and their embodied experiences of living with mental health problems, directly influencing identity. Interestingly, this has been recognised as a common process for those diagnosed with both mental health problems (Crabtree, Haslam, Postmes &

Haslam, 2010; Yanos, Roe & Lysaker, 2010) and those diagnosed with long-term conditions (Dennison, Moss-Morris, & Chalder, 2009; Kerns, Sellinger & Goodin, 2011) with many people identifying that 'being labelled' (receiving a diagnosis) can be stigmatising and clarifying concurrently (Yanos, Roe & Lysaker, 2010). When treating individuals with a long term diagnosis the process of psychological treatment often focusses upon the meaning of diagnosis for individuals, in order to help the process of adjustment (Park, 2010; Yanos, Roe, Lysaker, 2010). This process appears to be absent in the experiences of treatment and therapy for many participants in this study. Currently, treatment in a high secure hospital mainly focusses upon supporting individuals to manage their mental health problems and reducing risk. Consequently, it would be suggested that this should be an important element of therapy to be integrated into current provision

The political, legal and healthcare systems in place appear to augment feelings of powerlessness and a lack of collaboration as being a part of the subjective experience of being a forensic service user. Despite this, some participants highlighted the importance and benefits of positive relationships with individual staff members. This suggests that there may be merit in using these individual relationships to address issues of adjustment and help with the rehabilitation process. There is also emerging evidence that the role of clinical psychology could be further established within staff teams to support the wider MDT to understand these processes. This could be achieved by raising the importance of person-centred care and collaboration in staff supervision, reflective practice groups and through staff training (Gudjonsson, Webster, & Green, 2010).

The incorporation of a 'patient' identity for most of the participants may reflect the ascendancy of the biomedical model into institutional care. It has been argued, however, that the rise of the multi-disciplinary approach to care is diffusing the power of psychiatry (Rogers, Vergare, Baron, Salzer; 2007). Psychological approaches offer alternative, integrative models of understanding which can help manage the adjustment to an illness identity and support recovery (Yanos, Roe, Lysaker, 2010). However, with clinical psychologists now assuming the position of 'Responsible Clinicians' (RCs), care must be exercised

in ensuring that power systems and struggles that patients have had with the medical fraternity are not reproduced. This would not help the cause of fostering collaboration. *[See section 4.4 for further discussion: Implications for Practice]*

Limitations of the Study and Future Directions

The men in this study depicted a position of being constantly monitored and observed by authoritarian powers. It is, therefore, possible that the participants were reluctant to give responses that might threaten aspects of their treatment or relationship with the care team. Effort was taken to minimise this risk through reassuring participants that their responses would be confidential and that the interviewer was independent of the hospital. The impact of the interviewer holding the title of 'trainee clinical psychologist' and being affiliated to one of the professional groups involved in direct care of the participants cannot be discounted. It should be considered how much the participants may have told us what we wanted to hear. There was unavoidable selectivity in the recruitment process with patients who were unwell being excluded from the study. Power hierarchies, once again, determined whose voice was heard in this study with RCs determining who could and could not participate. This may have resulted in producing themes which are salient to the experiences of 'compliant' participants.

The results of this initial exploratory study highlight a number of tensions for those receiving forensic care and rehabilitation. The assumption that the problem is within individuals is one that has been assimilated by the legal system, social policy, the institution which provides treatment as well as those who are receiving treatment. In locating responsibility for difficulties and change within individuals the impact of societal factors in crime and to some degree mental illness are underemphasised (Denny, 2005; Ward & Maruna, 2007). This creates both public intolerance and stigma and creates a challenging environment for prioritising approaches that promote equality and inclusivity of those transferred to forensic services. *[See section 4.5 for further discussion: Limitations and section 4.6 for further discussion: Future Directions]*

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Extended Paper

I know not whether Laws be right,
Or whether Laws be wrong;
All that we know who lie in gaol
Is that the wall is strong;
And that each day is like a year,
A year whose days are long

Oscar Wilde, The Ballad of Reading Gaol
Irish dramatist, novelist, & poet (1854 – 1900)

1.0 Extended Background

1.1 Institutionalising Practices of History

In order to understand current practices towards offenders with mental health problems it is important to understand their development in the context of historical perspectives on 'badness' and 'madness'.

In the 16th and 17th century sanctions on criminal behaviour were public events which were designed to shame the person and discourage others (e.g. use of the stocks or pillory), with prison being the place where people were held until their trial or punishment, which was often death (Foucault, 1979). However, after two centuries of these practices shaming exercises and capital punishment were being regarded as outdated and imprisonment was seen as an effective alternative. The 19th century saw the birth of the state prison in London in 1816 and then in 1842 Pentonville prison, which is still used today. This was created using Jeremy Bentham's panopticon design (Vanstone, 2000), cementing incarceration as the primary form of punishment. By the end of the century prisons were controlled centrally through the formation of the Prison Commission which was shortly followed by The Prison Act 1898. This Act has been understood to underlie today's prison policies, by establishing that prison should be a place of rehabilitation rather than of hard labour (punishment). It was from here that the development of the prison system continued into the 20th century, with the borstal system for young people and formation of the Criminal Justice Act 1948. This inaugurated a comprehensive system of institutions, (such as remand centres, detention centres and borstal) for the punishment and treatment of offenders with prison at the centre. Although the system to manage those who have committed criminal acts has evolved over time, the fundamental principle of protecting society through the removal of offenders remains.

Responses to individuals with mental health difficulties have varied throughout history. Since the early 19th century those who displayed unusual thoughts and behaviours were confined to asylums. This detention of 'the mad' was slowly legally authorised, with the creation of the County Asylums Act, then Victorian Lunacy Acts and then the Mental Health Act (1983, 2007), which placed the

'state' as responsible for these individuals. This led to the creation of large specialised institutions to detain the 'insane'. It is in these institutions that the examination and treatment of those with mental health problems became a part of the medical profession where it remains entrenched to this day (Boyle, 2000). It is through these historical developments that the process of institutionalising those considered to be mad became common practice. More recently, the introduction of pharmacological treatments meant that the management of people with mental health difficulties could be effectively undertaken within the community. By the late 1980s significant numbers of institutions had closed and care in the community became the norm (Boyle, 2000). However, this has presented particular difficulties in relation to those with mental health problems who present a risk to society (and themselves), in particular, offenders with mental health issues. In this context the provision of forensic institutions, such as secure hospitals, provide the answer for containment and risk management as well as a place to treat such individuals. These establishments can be seen as one of the final layers of 'institutionalisation' which still exists in contemporary care and rehabilitation in the UK.

Paradoxically, what appears to be a mechanism to protect society and rehabilitate individuals may in the long run be less effective. Evidence from Scandinavian countries that have attempted to deinstitutionalise the care of offenders indicates a reduction in rates of recidivism when compared to the UK (Deady, 2014). Interestingly, in these countries the main principle guiding rehabilitation is that of 'normality' meaning that with the exception of freedom of movement, offenders maintain all other rights, so incarcerated life resembles 'free life' as much as possible, which improves chances of reintegrating back to society (Adams, 2010). When considering the treatment of offenders with mental health problems in the UK and the role of secure hospitals, it is worth noting that the primary mechanisms for safety and risk management share similar characteristics to a prison environment. These mechanisms limit not only freedom but access to many fundamental components of everyday life, such as relationships and the ability to exert autonomous choice. It is the restriction of these aspects of day-to-day life which brings into question how successful

treatment can be if the aim of rehabilitation, for both prisoners and those with mental health problems, is to integrate individuals back to society?

1.2 The Role of Power

Societies are shaped by an array of rules, systems and organisations which influence human interaction (Giddens, 1979). These structures allow people to exist together in a more or less ordered way, not only through governing behaviour but also by determining social and individual norms. It has been theorised that these systems and rules emerge from a complex arrangement of power dynamics. In the context of considering the development of practices which influence the care and punishment of individuals in any society it is important to recognise that wider ideological and political agendas shape policy, practice, attitudes and expectations through the direct and indirect use of power (Masterson and Owen, 2006). Existing responses to rehabilitation of criminals and those with mental health problems are shaped by the context in which they occur. An understanding of the historical practices of institutionalisation is covered above whilst a discussion of recent shifts in policy will follow, however in order to understand the development of these processes it is important to understand the role of power. Power can be understood as an active influence which shapes current responses to risk and mental health problems, as well as outlining preferred ideals about the role of rehabilitation and deviance. Power is actively taken away from criminals, by detainment on one hand, and attempts to empower those experiencing mental health problems on the other. However, both these practices are united in the fact that both groups remain subject to the existing hierarchies, with those empowering and suppressing maintaining the prevailing hierarchy. The unequal distribution of power can be seen to be maintained by the use of policy and law to protect the rights of those who maintain the rules of law and the disempowering nature of restricting one's liberty.

There have been a number of theorists who have proposed ideas about the mechanisms of power, however for this thesis the work of Weber, Lukes and Foucault (1979); Weber (Kumar, 2000; Weber 2009) conceptualised power as a finite resource to be prohibited or granted and is relevant as acts of detainment

could be seen as a way of withdrawing power from the individual and privileges control and imposition from those still accepted in society.

Lukes (1974) describes power as existing on three faces or dimensions. The first dimension is implemented through open decision making, whilst the second and third dimensions describe more covert mechanisms of power. The second dimension describes how agendas may be controlled to exclude options which do not fit with the overarching aims of the system. The third dimension refers to the ability to shape identities, hopes and aspirations of others, allowing them to “accept certain situations without conflict” (Masterson & Owen, 2006, p.21).

At the third face of power, Lukes links his ideas with those of Foucault (1979). Foucault’s work was primarily concerned with the relationships between knowledge, ‘truth’ and power as a mechanism which exercised control. Foucault suggested that groups which hold specialised knowledge, such as medicine, develop powerful discourses which shape socially acceptable ways of understanding reality. It could be argued that the development of psychiatric and psychological discourses which construct mental illness as a biomedical entity has become the dominant narrative, shaping current responses to it.

Considering the role of power on the situation of those transferred from prison to high secure hospitals for the treatment of mental health problems is paramount when reflecting on the systems which operate. If we consider these processes in relation to forensic services, the first face of power could be seen to be constructed in relation to direct government policies and institutional rules governing a person’s stay.

The second face focusses on the agenda, which in this context could be argued to be the overarching principle of treatment and rehabilitation. The focus on these individuals shifts from the CJS’s focus of detainment and punishment, to the healthcare priority which emphasises rehabilitation and treatment. In short the agenda shift from the ‘bad’ to the ‘mad’. Finally, the third dimension of power operates on individual identity with the incorporation of the ‘patient identity’, subject to the discourses of psychiatry and psychology.

1.3 Total Institutions

In his seminal work, *Asylums* (1961) Goffman identified five types of institution: hospitals, asylums, prison, establishments for education and those for religion (such as convents). He defined them as 'Total Institutions', which were all encompassing of daily activities, where people who share similar social situations are cut off from wider society. Goffman suggested that Total institutions may be characterised by bureaucratic control and operate through a process he named 'mortification of the self'. Mortification of the self refers to the processes of the institution which support the loss of individual identity, such as confiscation of personal belongings, the issue of uniforms and prisoner numbers. These practices in an institution mark a separation from the outside world, allowing the individual self to be 'given up', and instead identity becomes defined by the social processes of the institution.

With shifts in modern healthcare aspiring towards delivering patient-centred care, it might appear that the practices inherent in total institutions have been mitigated by a focus on individualised care and the move towards deinstitutionalisation. However, for many people the transition into secure hospitals is marked by the confiscation of personal items and the loss of control over the minutiae of daily life. Although Goffman's typology should be a phenomenon of the past, it is worth considering how clients may experience organisational processes which are often taken for granted with questions being raised about some healthcare practices which may be totalising through clinical need and / or the policy processes which define them. There appears to be a need to critically examine and evaluate the systems we have designed to provide care for vulnerable adults from the experience of the clients, in order to truly diminish totalising processes that may be inherent in organisational systems.

1.4 Criminal Justice versus Healthcare

The aim of the UK criminal justice system is to 'punish the guilty, protect our liberties, and rehabilitate offenders. We will ensure that more criminals make amends to victims and communities for the harm they have caused and help them break the destructive cycle of crime.' (www.gov.uk). Conversely, the

Ministry of Justice (MoJ) green paper, 'Breaking the Cycle: Effective Punishment, Rehabilitation and Sentencing' (MoJ, 2010) identifies that despite record spending and rising prison populations the system is not 'delivering what really matters: improved public safety through more effective punishments that reduce the prospect of criminals reoffending' (p.5).

In contrast, UK healthcare is provided by the National Health Service (NHS) and states its central values as working together for patients as a guiding tenet; to treat everyone with respect and dignity; to provide safe; effective quality care; to provide compassionate care; to improve lives; and finally to distribute resources equally (DoH, 2013). Integrating these disparate philosophies into a secure forensic setting which can support rehabilitation for individuals can prove to be a challenge.

Although provision of services is provided by two separate and distinct systems, there are a large number of individuals who fall under the needs of both. The most recent report from the Offender Health Research Network (OHRN, 2011), stated that severe mental illness is present in 23% of the prison population, 19% show symptoms of major depression and 4% suffer from psychosis. Alongside this, 66% of the prison population have a substance misuse problem with dual diagnosis being present in 18% of the prison population. Overall, 71% of the prison population has a severe mental illness, substance misuse problem or both.

Explicit government policy has been in place since 1990 to outlining a process of 'diversion' (Laing, 1999). The aim of this was to reduce the role of the criminal justice system and increase that of the health system for those with a severe mental illness or learning disability. A recent independent review by Lord Bradley (2009) identified that the implementation of diversion policy has been inconsistent across the country, often with long delays for transferring acutely unwell people to hospital. Lord Bradley's report highlights that the prison environment is not appropriate for those suffering with severe mental illness, as it may exacerbate mental health problems and increases the risk for self-harm and suicide. The Bradley Report goes on to recommend that the government

should aim to develop a minimum target of 14 days to transfer a person with severe mental illness to an appropriate healthcare setting. In line with this, the MoJ green paper concludes that reform of the justice system is required with a focus upon effective rehabilitation, which includes providing effective treatment of those with mental health problems.

Integrating the disparate philosophies of the criminal justice and health care systems into secure mental health services, aimed at supporting rehabilitation for individuals, can prove to be a challenge. This is particularly highlighted when set against practice and policy developments such as the adoption of patient-centred care. There has been considerable acknowledgement of the ethical dilemmas faced by clinicians working in forensic settings in balancing priorities of justice and public protection against those linked to individual wellbeing and autonomy (Adshead, 2000; Ward, 2013). Whilst it is not within the scope of this paper to review in detail the dilemmas faced by clinicians working in forensic practice, it is important to understand that there is often a distinct clash between professional roles and that of overarching policies. It has been suggested that policies often influence and even outline the role of the professional within forensic settings, with a forensic clinician being expected to prioritise the process of justice and public protection over the welfare of those detained (Adshead & Sarkar, 2005; Appelbaum, 1997; Sadoff, 2011). This is not to say that wellbeing is dismissed by rehabilitation, but stresses that public safety is paramount when treating individuals (Vassilev & Pilgrim, 2007). In addition, the introduction in British Psychological Society's Code of Ethics and Conduct (2009) states the profession needs to be 'mindful of the need for protection of the public' (p 2) as an opening assertion.

It has been suggested that the difficulties in providing care in the intersecting boundaries of the CJS and healthcare system comes from the principles of value pluralism (Ward, 2013). Engelhardt (1986) identified that value pluralism occurs when a variety of ethical codes or norms is outlined by society, with none being determined as ethically superior. This allows for ethical clashes to occur 'horizontally' or 'vertically'. Horizontal clashes are between ethical codes seen as the same level, such as between two professions, such as a care

professional and an employee of the CJS, whilst vertical conflict may occur between overarching systems, for example human rights norms set against security in a high secure hospital. These conflicts can occur within organisations, systems and even within individual.

In response to the identified complexities and ethical dilemmas clinicians face when working in forensic settings, there has been suggestions by forensic clinicians that an overarching framework be developed for managing the rehabilitation of offenders with mental health problems (Adshead, 2014; Barnao, Ward & Casey, 2014; Robertson, Barnao, Ward, 2011).

1.5 Human Rights and Mental Health Law

The European Convention on Human Rights (ECHR) is an international treaty acting to protect human rights, which in the UK is embedded within common law. This has led to some scrutiny of UK mental health law, and in particular the Mental Health Act (MHA) in relation to the ECHR. Reviews of the judgments made by the European Court of Human Rights (Gostin, 2000; Bindman, Maingay, Szmukler, 2003) has mainly considered Article 54 (deprivation of liberty) and on occasion Article 35 (inhuman treatment) (Bindman, Maingay, Szmukler, 2003). However, except for few notable cases, most rulings have found that continued detention and compulsory treatment are acceptable with the violation of individuals' rights deemed to be proportionate (Bindman, Maingay, Szmukler, 2003).

1.6 Psychological Impact of Detention

Research from the Prison Population

There has been a wide variety of research documenting both the negative psychological effects of detention in the prison population (Sykes, 1958; Haney, 2003; 2012) and how people adjust to prison life (Clemmer, 1958; 1940; Dhami, Ayton, Loewenstein, 2007; Piepgras, 2006; Sykes, 1958).

Life in prison has been recognised to be stressful (Toch, 1977) which has long been understood as the degree to which those detained can endure the 'pains of imprisonment' (Sykes, 1958). These have been defined and identified as the deprivation liberty, autonomy, security, relationships and goods and services

(Sykes, 1958). The loss of liberty has often been recognised as the main mechanism of punishment (Foucault, 1979; Sykes, 1958). Additionally, research exists to indicate that a lack of autonomy is associated with psychological distress (Goodstein, MacKenzie & Shotland, 1984; Wright, 1993) as well as poor psychological health being associated with a lack of contact with friends and family (Liebling, 1992; Wooldredge, 1999). Whilst Dye (2010) suggests that modern prisons vary to the degree that they are 'cut off' from wider society, the pains of imprisonment still exist and their impact on psychological wellbeing well documented (Haney, 2012).

Debate exists to the extent of psychological damage prison causes (Bonta & Gendreau, 1990, Haney, 2003; 2012), however it is recognised that maintaining good mental health in the prison milieu is challenging. As Haney (2003) states "few people are completely unchanged or unscathed by the experience" (p. 4). It has been reported that about 90% of adult prisoners have at least one mental health problem; approximately 70% have two or more mental health problems; with rates of attempted suicide being high in prison (SCMH, 2009).

Although forensic hospitals serve a different function, the primary mechanisms for safety share similar characteristics to a prison environment. As individuals are legally detained, it can be assumed that their ability to exert autonomous choice and control over their situation is limited. Given that rehabilitation should aim to improve wellbeing and promote autonomy the extent to which this can be achieved in both the physical environment and ethos of secure hospitals is questionable.

In addition, there is a wide variety of research which investigates adjustment to imprisonment which has proposed two main theories of adjustment in prisons – the deprivation model and the importation model. The deprivation model (Sykes & Messinger, 1960; Thomas & Petersen, 1977) examines the extent to which adaptations are based on the prison environment (such as, isolation, lack of freedom, loss of relationships). This model suggests that people adapt to the stressful and oppressive conditions through a process of 'prisonisation' by forming new attitudes and behaviours reflective of the prison culture (Clemmer,

1958; Sykes, 1958). The importation model (Irwin & Cressey, 1962) of adjustment focuses on the role of pre-prison characteristics and attitudes of individuals (such as, age, sex, class, education and employment) that are 'imported' into prison. There has been some research which has investigated the interaction between imported characteristics and deprivations of prison with the models being seen as compatible in conceptualising how well prisoners will cope with imprisonment (Gover & MacKenzie, 2003; Toch & Adams, 1989; Wright, 1991). It is worth noting that these studies of adaptation use correlational or cross-sectional design making it challenging to determine the mechanisms of adaptation (Zamble & Poporino, 1988) and more simply describe uniform behaviour in prisons. In order to understand adaptation processes, it has been suggested that using a stress and coping model based on an interactionist view of the person-environment may provide a better conceptual framework, such as theories of coping (Folkman & Lazarus 1984). Whilst these models are based on prison culture, they may offer some framework to understand individual adjustment when detained in a secure hospital.

Adaptation to Imprisonment Over Time

Studies have found differences in adjustment when comparing people who have spent varying amounts of time in prison, with a lack of negative effects of long-term incarceration. Some studies found that long-term prisoners increased participation in work and activities (Zamble 1992). Some have reported that there are reduced feelings of hopelessness over time (Zamble & Porporino, 1988), no deterioration in terms of depression, although the early period was stressful. Interestingly, similar findings have also been reported for people serving sentence of life without parole in the USA (Leigey, 2010), with individuals reporting that their mental health had improved over the course of incarceration.

The lack of adverse effects of long-term sentences should not be viewed as an endorsement of long-term incarceration and perhaps should rather highlight the strength and resilience of individuals (Leigey, 2010).

Experiences of Being Detained Under the MHA

There has been a small but growing body of literature looking into individual experiences of involuntary hospital admissions (Gilbert, Rose, Slade, 2008; Katsakou & Priebe, 2007; McGuinness, Dowling & Trimble, 2013). These studies have shown that individual experiences are diverse and vary hugely. The studies highlight both positive and negative themes across a continuum from individuals feeling the benefits of treatment, being cared for, respected and autonomous at one end, to feeling not being cared for, uninvolved in treatment decisions and feeling frustrated by the restrictions in autonomy (Katsakou & Priebe, 2007). The common theme across the studies was the value of supportive relationships with staff, which helped ameliorate the negative aspects of detention. It could be argued that this advocates the importance of meaningful therapeutic relationships in the context of mandated treatment.

1.7 Patient-Centred Mental Health Care

Recently, there has been a strong push towards models of mental health service delivery that are patient-centred and recovery orientated (National Institute for Mental Health in England; 2005, Department of Health, 2009; Department of Health, 2011). The UK policy document “No Health without Mental Health” focuses on the implementation of patient-centred principles as underpinning good practice, advocating that all health services governing principle, including mental health services, should be ‘No decision about me without me’ (DoH, 2011, p.3)

Principles of patient-centred care describe an approach to healthcare which promotes and respects the choices and values of the patient. A conceptual framework of patient-centred care identifies five key dimensions which are outlined as:

- 1) Taking a biopsychosocial perspective. This suggests that health should be viewed holistically taking into account social and psychological perspectives as well as biomedical.
- 2) Understanding the meaning of ‘illness’ to the patient, known as the ‘patient-as-person principle’

- 3) Sharing power and responsibility with the patient, allowing for them to collaborate in their own care.
- 4) Building therapeutic alliance with the patient and empower them to collaborate in their own care.
- 5) An awareness that the personal qualities of the provider affects the quality of care (Mead & Bower, 2000)

Research has shown that involving patients in the planning and delivery of their care improves engagement and outcomes (Resnick & Rosenheck, 2008; Sidani, 2008; Warner, 2010) and promotes recovery. Given the focus on safety and risk management in forensic settings, patient centred care has not historically been a priority. However with all current UK mental health policy (National Institute for Mental Health in England; 2005, Department of Health, 2009; Department of Health, 2011) emphasising the need to deliver patient-centred care, consider notions of wellbeing and work towards recovery as significant aspects of effective service provision.

Rehabilitation Goals

Over time, there has been a shift in treatment of mental health problems from largely biomedical, diagnostic models to conceptualisations that encompass not just illness, but concepts of wellbeing and recovery. In short, the focus is not just on reducing symptoms and containing risk, but also improving 'mental health' (Boyle, 2000). Consequently, the focus of psychological treatments in forensic settings has followed this trend incorporating treatments designed to improve wellbeing and promote recovery. There is an increasing awareness that focusing on psychological wellbeing would be valuable in terms of improving overall outcomes for those detained in secure settings (Ferguson, Conway, Endersby, & MacLeod, 2009), particularly in light of the importance placed on patient-centred and recovery approaches to mental illness.

Given the context of treatment in high secure hospitals this task could be seen as being more complex for forensic mental health clinicians (Simpson & Penney, 2011). Maintaining the principles of wellbeing and recovery at the heart of therapeutic work in an environment which restricts an individuals' liberty and provides compulsory care and treatment is a complex task. Despite this

paradox, some have suggested that addressing the concepts of security in therapy are crucial to the recovery of forensic mental health service users – in order to be rehabilitated back to society, both aspects of illness and offending have to be addressed. Consequently, rather than seeing security and treatment as being in opposition to one another, it may be necessary to support both within the recovery perspective when working in forensic mental health settings (Davidson, O'Connell, Tondora, Styron, Kangas, 2006). Indeed it is reasoned that recovery cannot be achieved without addressing offending behaviour as it has been argued, 'It is evident that one cannot attain a 'life worth living' and continue to offend' (Simpson & Penney, 2011; p304).

Constructing a single definition of 'wellbeing' has proved to be complex and there are a number of theoretical perspectives on what compose the essential features of psychological wellbeing and how it can be operationalised (Dodge, Daly, Huyton, & Sanders, 2012). Common themes in the literature range from seeing wellbeing as a tangible state, made up of various components such as, self-acceptance, positive relations with others, autonomy, environmental mastery, purpose in life and personal growth (Ryff, 1989). Alternatively, others define it as a self defined assessment of an individual's satisfaction and quality of life (Shin & Johnson, 1978).

Regardless of the definition, working with individuals to improve their psychological wellbeing requires an understanding of what it means from the individual's subjective perspective. Offenders transferred to secure settings may well face additional difficulties in establishing their own sense of wellbeing given the context in which they live. Within the prison population, considerable research exists suggesting the negative impact of incarceration (The Sainsbury Centre for Mental Health, 2009). For those detained within a secure hospital, no research currently exists exploring this issue, however, it is reasonable to assume that similar issues may arise. For the purposes of this study, the term wellbeing is used as a generic term, drawing on the individual participants subjective perspectives.

Principles of the recovery movement are linked to understanding what constitutes psychological wellbeing. The underlying philosophy of recovery is

that individuals can experience a satisfying life and 'life worth living' (Simpson & Penney, 2011) and is therefore not signified by the absence of symptoms of mental illness, but is seen as a personal experience which encompasses concepts such as hope, empowerment, meaning and purpose and desire for change (Repper & Perkins, 2003).

Person-centred approaches focussing on recovery and wellbeing accord individual experience a central position in formulating responses to mental health problems. In order to work effectively with people transferred from prison to secure hospitals, who find themselves managing the experience of an indeterminate sentence, it would seem essential to explore the issue from the individual's perspective.

1.8 The Context of the High Secure Hospital

Individuals with mental disorder or neuro-development disorder who are detained under the Mental Health Act (MHA 1983) and whose risk of harm to others and risk of escape from hospital cannot be managed safely within other mental health settings, require care and treatment within a secure mental health service.

Individuals are usually recognised as having complex mental health problems, with co-morbid difficulties of substance misuse and/or personality disorder, which are linked to offending or seriously irresponsible behaviour. Consequently most individuals are involved with the criminal justice system, the courts and prison system with many having Ministry of Justice restrictions imposed (MoJ, 2010).

In order to manage risk, the therapeutic environment is carefully managed through the delivery of a range security measures. A number of levels of security currently exist to manage increasing levels of risk to others. Presently these consist of High, Medium and Low secure services, each of which provides a range of physical, procedural and relational security measures to ensure effective treatment and care whilst providing for the safety of the individual and others including other patients staff and the general public.

All individuals admitted to High Secure Psychiatric Services are detained under the Mental Health Act (1983 amended in 2007) and meet the criteria defined by the NHS Act 2006, for people who “require treatment under conditions of high security on account of their dangerous, violent or criminal propensities.” High Secure Services are provided in hospitals that have physical security arrangements equivalent to a category B prison. However, they can treat individuals who in a prison setting would be in a category A or B environment (NHS Commissioning Board, 2013).

The decision to admit or transfer to a secure service is based on a comprehensive risk assessment and consideration of how the risks identified for each individual can be safely managed whilst in a hospital setting. As mentioned, the majority, but not all of those admitted to High Secure Services, will have been in contact with the criminal justice system and will have either been charged with or convicted of a violent criminal offence. High Secure Services play a key role in assessing an individual’s ability to participate in court proceedings and in providing advice to courts regarding disposal following sentencing.

High Secure Psychiatric Services comprise of three hospitals which provide services for the populations of England and Wales with NHS Scotland commissioning one further high secure hospital. Each of the high secure hospitals serves a defined catchment area for those diagnosed with a mental illness or personality disorder. In 2013, there were approximately, 795 inpatient beds in high secure, 3192 in medium security and 3732 in low security commissioned for England and Wales. The three hospitals in England are expected to work collaboratively to achieve consistency in policies and practice to ensure there are equitable high secure services for patients regardless of which hospital the patient is placed (NHS Commissioning Board, 2013).

The core objectives for all three high secure services in England is to assess and treat mental disorder, reduce the risk of harm that the individual exhibits to others and to support recovery. Secure services provide a comprehensive range of evidence based care and treatment, provided by a range of professionals. A range of both specialist offence related and mental health treatment programmes, delivered either individually or within groups, are

available (NHS Commissioning Board, 2013). Offence related work typically includes sex offender treatment programmes, aggression management programmes and programmes to address fire setting (NHS Commissioning Board, 2013). The aim is for the individual to safely move on to a less secure service or safely return to prison. A key principle underpinning the provision of secure services is that individuals should be managed in the least restrictive environment possible in order to facilitate their safe recovery. Least restrictive refers to the therapeutic use of the minimum levels of physical, procedural and relational measures necessary to provide a safe and recovery focused environment.

The High Secure Hospital in this Study

The high secure hospital in which this study took place is currently divided into five services - mental health, national learning disability, national woman's service; and a personality disorder service. Each service has a specific treatment pathway that targets criminogenic, risk, and mental health needs. However, as each person is detained under the MHA, they are therefore subject to the Care Pathway Approach (CPA). This means that an individual's treatment pathway is based on their own Care Plan and therefore individualised to meet their needs. Treatment is provided using individual and group interventions, dependant on need, which is planned and outlined using the CPA.

Everyone admitted or transferred to the high secure hospital in this study undergoes a period of specialist assessment in order to understand and plan the requirements for their treatment. Following this, each service provides an introductory group (tailored to the population of each service) which everyone is required to attend. The aim of these groups is to prepare people for therapy and treatment. Following this, each individual follows the treatment pathway outlined in their own individualised care plan.

1.9 Time Perspectives

The passing of time is a fundamental feature of all human experience regardless of an individual's context. The investigation of time perspective explores how human experience is understood in temporal categories such as past, present or future (Boniwell & Zimbardo, 2004). It is a broad term that

encompasses how we subjectively organise events, experience the passing of time or a specific duration and also how we manage the minutes and hours in a day (Zimbardo & Boyd, 1999). It has been proposed that the monitoring of time is a basic developmental function that is central to cognitive functioning (Suddendorf & Corballis, 1997) allowing people learn from experiences and form expectations. A number of models and theories have been proposed to demonstrate how different temporal categories (e.g, past, present or future) are considered in the decision making process, influencing behaviour in the present moment (Lewin, 1951; Nuttin, 1985; Block 1990, Zimbardo & Boyd, 1999). The formation of a person's time perspective is subjective and learned through aspects of socialisation and experiences.

More recently, the idea of a Balanced Time Perspective has been offered, which is defined as the ability to be able to switch between past, present or future time perspectives (Zimbardo, 1999). It has been suggested that it is most beneficial for individuals to be able to switch flexibly between different time perspectives depending on the task, situation, or personal resources rather than to constantly bias one specific time perspective that may not be adaptive across all circumstances. By achieving a balanced time perspective, an individual's decisions are shaped by all three of the temporal categories, in contrast to the limited perspective of a single biased time perspective (Zimbardo & Boyd, 1999; Boniwell & Zimbardo, 2004). For example, there are times when it is beneficial for people to focus on future achievements or goals in order realise their potential, just as there are instances where one must reflect on their past to establish or remind themselves of their previous experiences or personal identity. In addition, circumstances are also presented where focusing on the present will serve to expose you to new experiences and enrich your life. Zimbardo and Boyd (1999) developed the Zimbardo Time Perspective Inventory (ZTPI) in order to test and operationalise their hypotheses on past, present and future time perspectives. This research has focussed upon the fact that individual's process time in a subjective nature, whereby they psychologically reconstruct events and outcomes in order to better understand their experiences and to help them to form future expectations. In considering time perspective research, it is worth noting that Bandura's self efficacy theory

(1997) explains how individuals regulate behaviour by constructing self efficacy beliefs that are shaped by past, present, and future time frames. Bandura asserted that people form beliefs about their ability to succeed at a task based on their past experiences, current appraisals, and expectations of their future opportunities. Through synthesising this information individuals then either engage in a particular behaviour or refrain from it.

Although time perspective theories provide a framework to understand how individuals process experiences in order to inform decision making, it is unclear how being detained indeterminately for treatment and rehabilitation may influence this. It could be assumed that people detained indeterminately for treatment purposes may have difficulty in determining future goals for their rehabilitation, given that there is no clear cut time frame for the 'future'. However, it could also be argued that the 'future' is unclear for us all and that individuals are able to operate on a day-to-day basis proceeding with imprecise notions of 'the future' in mind. To understand how time perspectives influence those detained with an indeterminate sentence subjective experience of this context needs to be explored further.

2.0 Extended Methodology

2.1 Rationale for Qualitative Methodology

What there is to know about the world and how this is explored has been an ongoing deliberation between quantitative and qualitative research methodologies, encompassing a spectrum of ontological and epistemological positions (Willig, 2001). Finding an appropriate methodology which fits with both the philosophical understanding of knowledge and addresses the aims of the research is of paramount importance. Having contemplated both these aspects of the research the decision was made to select a qualitative mode of enquiry.

Qualitative methodology is primarily concerned with understanding how 'people make sense of the world' (Willig, 2001; p9). It aims to understand how meaning is created through exploring the personal experiences of people. In addition it is considered appropriate in a novel area of research, which has little pre-existing knowledge (Barker, Pistrang & Elliot, 2002).

2.2 Conducting Interviews

Semi structured interviews were felt to be useful in allowing the participant to share their experience, whilst allowing the researcher to incorporate the participants' own language and concepts, encouraging participants to express otherwise implicit assumptions and thus generate novel insights (Willig, 2001) in relation to the research question.

Interviews took place in March and April 2013 and were facilitated by the principal researcher (Interview schedule: Appendix B). The use of an interview schedule allowed for a structure to 'guide rather than dictate the interview' (Smith, 2008, p58). An open and flexible approach was adopted by the researcher, informed by the suggestion that participants may respond to questions dependant on what they believe to be the motive of the researcher (Cameron, 2001). Throughout the process the researcher recognised the impact of these perceptions, and adopted a curious position, which allowed for clarification and further questions if necessary, however kept challenges to a minimum, allowing for participants to guide the interview. The interviews varied in length ranging from 37- 86 minutes. Participants were offered a debrief

session following the interview, however no participant felt this was necessary and no one appeared to be distressed during the course of the interview.

2.3 Thematic Analysis

Thematic analysis (TA) aims to identify and analyse patterns within data sets to find repeated patterns of meaning and can be applied from a range of epistemological positions (Braun and Clarke, 2006). The epistemological stance aids transparency within the analysis process and informs how the researcher constructs themes, and in this case, the research was grounded in a social constructionist paradigm (Braun & Clarke, 2006).

Thematic analysis has been critiqued for being the basis for other qualitative methodologies and not a methodology in its own right (Ryan and Bernard, 2000), however, Braun and Clarke's (2006) six stage process outlines a clear method of analysis, giving it more clarity and structure, allowing for data to be analysed in a systematic and rigorous way. It was chosen for this research as it provides a broad yet transparent way of analysing a data set, when the specific topic has yet to be explored in depth. TA also allows for a flexible approach to data analysis, which can occur inductively, where themes emerge from the data (Boyzatis, 1998) or deductive, where themes are linked to a pre-existing framework or theory (Crabtree & Miller, 1999). Finally, TA can be conducted at using various levels – semantic or latent. At semantic level, themes are produced linked directly to the explicit meanings in the data (Boyatzis, 1998). TA at the latent level aims to identify or examine the “underlying ideas, assumptions, conceptualisations, and ideologies that are theorised as shaping or informing the semantic content of the data” (Braun & Clarke, 2006, p. 84). Both have some level of abstraction, but vary in the depth of interpretation.

For the purposes of this study, an inductive approach was used. This meant that the themes identified were linked to the data collected and not informed by a pre-existing framework. The data was firstly used to identify semantic themes in the data and then look into the descriptions participants produced about their experiences. The second part of analysis took place at the latent level, to

identify the broader meanings of the themes, allowing for the language, assumptions and constructions of the theme to be investigated (Patton, 1990).

It was recognised that using TA, from a social constructionist perspective, using a latent level of analysis may be seen as overlapping with a number of strands of Discourse Analysis (DA). Although the use of DA was considered, it was recognised that although language and discourse are the ways in which 'reality' is constructed, the aim of the study was to understand the experiences of men detained indeterminately for treatment and rehabilitation. Therefore, it was necessary to understand the meaning of their experience and not focus exclusively on the linguistic properties and how things were said.

The use of Interpretive Phenomenological Analysis (IPA) was also considered as it allows for the exploration and understanding of a phenomenon from an individual's perspective (Smith, Flowers & Larkin, 2009). Whilst both TA and IPA focus on an individual's experience and take an interpretive approach to constructing themes, it was felt that the phenomenological and hermeneutic issues may have restricted analysis. It was felt that TA allowed more flexibility in understanding and constructing meanings from the data.

2.4 Ethical Considerations

The project was informed by the British Psychological Society Ethical Guidelines (Francis, 2009). Ethical approval was initially gained from the University of Lincoln's Ethics Committee. Following this, NHS approval was applied for from Nottingham Research Ethics Committee and the relevant NHS Research and Development department (see Appendix C).

Throughout the research process consideration was given to gaining the consent from men who are legally detained and extremely vulnerable in relation to their mental health problems and the sensitivity of the research topic.

A real question of consent for conducting research with this population is how much ability does someone really have to say 'no' if they are being detained legally? There is an argument that due to the circumstances of being both

legally detained and suffering from mental health problems, that forensic service users have little actual choice. It has been argued that due to their mental health problems individuals may be 'internally' constrained, and due to the legal sanctions on their liberty, they are 'externally' constrained (Adshead & Brown, 2005). This then additionally raises the ethical question that given the circumstances of the individual, by simply asking someone to participate in research, is there an element of coercion? For this study, the researcher was aware of this power dynamic inherent in the situation and attempted to take steps to ameliorate this.

As with all research, establishing whether someone has capacity to give informed consent is good practice and prior to contacting any participant, permission to approach patients was gained from responsible clinicians (RCs). This was so anyone lacking in capacity or deemed too 'unwell', at the time of recruiting, would not be contacted.

In order to reduce the power imbalance, participants were initially contacted by a letter from the researcher. It was hoped that this would lessen the pressure to respond, as there would not be an embodied person to refuse in a face-to-face interaction. The information sent to participants was worded to make it clear that participation in the study was voluntary and would not affect care or legal rights (Appendix D). The procedural idea to hold a 'drop-in session on the home ward of the participants to answer questions was carefully considered. The main dilemma held by the researcher was the need to provide enough opportunity to clarify questions and provide enough information for people to be 'fully informed' before consenting; whilst balancing the opportunity for individuals to be able to refuse a 'real person' (as opposed to a distant faceless name on a letter), following the meeting. It was felt that the opportunity to answer questions and queries outweighed the potential pressure to agree and hence drop-in sessions were offered. Care was taken during the drop-in sessions to emphasise that participation was voluntary, and the research was being conducted independently of the organisation. It was also stressed that the researcher was not a member of the care team, to help lessen the pressure to agree to be involved.

It was made clear to all participants that they could withdraw their consent at any time up to agreeing to take part in the study and the week following their interview. It was explained that after a week, interview data may have been transcribed and anonymised so it would be difficult to destroy the interview data following this. Once again, it was felt that this was an important consideration to the research process - researching a population who may not have the ability to exert as much choice as other populations, it was felt that if on reflecting on the interview a participant chose to withdraw their interview data, this should be accommodated in the research process.

The area of research for this study required discussion of sensitive topics on a personal level. This was made clear to people invited to participate in the study through the information provided and during the meeting to obtain informed consent. In order to plan for any adverse effects the nature of the interviews were discussed with the participant's care team prior to the interview and an agreed plan of support discussed. Participants were reminded before the interview commenced that they do not have to answer questions they felt uncomfortable with and that the interview could be stopped at any point. In the event that a participant became distressed during the course of the interview, it was planned and explained that the interview would be stopped and the researcher would discuss ways of managing the distress and would also inform the participant's care team. If further support was required, the third author, who was a member of staff at the hospital, would provide further continued support to the participant and care team. Fortunately, this planned additional support was not required to be used during the research process.

The final point of consideration was maintaining confidentiality and anonymity of the participants. This was done through identifying potential participants anonymously through only their patient number and the details of the mental health section they were detained by. Once identified, consent forms were stored separately to other information. All potential participants were allocated identifying codes and all data was then labelled with this, rather than names and wards and only the principal researcher had access to identifying information.

2.5 Sampling

Qualitative research does not prescribe the same rigid sampling procedures that are required in quantitative research (Coyne, 1997). Instead purposive sampling, allows participants to be recruited in relevance to the research question. For this study this participants shared the experience of being transferred from prison and being detained indeterminately for treatment and rehabilitation, for a period longer than their original sentence. This change was identified, as participants originally had a known date of release to now having an indeterminate detention period. This was so that the themes identified relevantly captured the participants' shared experience and tells us something about this situation (Willig, 2001). In order to increase homogeneity of the sample, specific inclusion and exclusion criteria, which are outlined below, were established prior to recruitment.

Men were only included if they were:

- Aged 18 and above
- Transferred from the prison service
- Detained under the Mental Health Act for a period longer than their original prison sentence
- Deemed to have capacity to give informed consent
- Able to communicate in English.

Men were excluded if they did not receive an original fixed length prison sentence or deemed 'too unwell' to be approached by their Responsible Clinician. This exclusion criterion was identified as men in this situation will not have experienced a change in detention period – their detention period has always been indeterminate from the time of entering a secure setting.

2.6 Procedure

Participants were recruited from the Mental Health and Personality Disorder services from a single High Secure Hospital in the UK (n=206). The services are

for adult males who have been diagnosed with a mental health disorder and have been sectioned under the Mental Health Act.

Identification of participants, gaining consent for them to participate in the research and conducting the interviews was done in several stages. Initially all potential participants were identified anonymously from information kept at the hospital (n=32). Once identified, permission was sought from Responsible Clinicians in writing to approach participants that were well enough to be included in the study (n=27).

Information about the research project was distributed to all men who met the inclusion criteria who were deemed well enough to be approached. This consisted of an information leaflet describing the study, a cover letter requesting participation, the dates of a drop-in session which the allowed potential participants to ask questions about the study. Patients interested in participating in the study were asked to complete an expression of interest slip and return it to their named nurse or Responsible Clinician. Once potential participants had shown an interest in participating in the study, a time to meet was arranged via the ward staff. This meeting was to answer any final questions and obtain written consent. Subsequently, convenient interview times were arranged with the participant and the home ward. These took place in a private room on the home ward of each participant (n=12). Interviews were digitally recorded and transcribed verbatim by the researcher or an employed transcriber and anonymised to ensure confidentiality.

2.7 Analysis

Thematic analysis was conducted based upon the six-stage process outlined by Braun and Clarke (2006, outlined in Table 5 overleaf). Ideally, the process begins with transcription of the data, followed by reading and rereading of the data, allowing the researcher to become immersed in the data, allowing for initial ideas and patterns to begin to 'emerge'. Due to the time limits of the study, the researcher transcribed two interviews, with the rest being transcribed by a professional transcriber.

An inductive approach was used where initial codes identified were linked to the data collected, not informed by a pre-existing framework. Initial codes and categories were noted down at the semantic level in the right hand margin next to the data. These initial codes not only identified aspects of the data which were relevant to the research question, but also highlighted interesting aspects of the discussion.

Table 5: Six Stage Process of Thematic Analysis (adapted from Braun and Clarke, 2006)

Stage	Process
Data familiarisation	Transcription of interviews, repeated reading, and noting down initial thoughts and ideas.
Generating initial codes	Systematically coding features of interest, and organising into meaningful sets in relation to research question
Searching for themes	Collating codes into potential themes, and gathering information relevant to each theme
Revising the themes	Checking themes work in relation to the data extracts and entire data set and generating a thematic map.
Defining and naming themes	Refining the themes, generating clear definitions and names for themes.
Producing report	Selecting themes and data extracts to report which reflect the research aim.

Following this, the initial codes were physically collated and organised into possible themes. This process required many alterations and amendments as initial themes evolved. Through this process connections began to be made between codes to initial themes. During this process, the original dataset was checked to ensure that the initial themes emerging represented the original data.

A second level of analysis of the themes involved discussion of the initial codes with the second author which facilitated analysis to occur at a latent level. This generated subthemes and themes, which were labelled to capture the 'essence' of the themes. Themes were then organised into a final thematic map

(Appendix A). Finally, the results were reported in relation to the research question.

2.8 Epistemology

This study aims to understand the experiences of men sentenced without limit of time from a social constructionist perspective. This approach hypothesises that language or discourse is part of our natural flow of interchanges with life and the world as we experience it, which in turn is the tool that shapes our realities and gives meaning to our experiences. Through discourse the social reality of individuals is constructed and understood (Willig, 2001). This paradigm challenges the ideas of a single observable reality proposing instead the idea of multiple realities which are socially constructed and individually experienced (Gergen, 1985; Burr, 1995). This stems from a line of reasoning that language and social practices are inextricably linked and can only be separated theoretically (Burr, 1995). Therefore, the social practices and culture in which we exist are produced and maintained through the discourses which surround it (Burr, 1995). Using this perspective 'knowledge' or the different accounts of the world is therefore seen as socially constructed and inseparable from cultural or historical context (Burr, 1995).

For this study, it seemed crucial to focus on the ways that men transferred from prison and detained without limit of time for treatment purposes, make meaning of their experience as well as the ways in which the broader social context impact on those meanings. This epistemological position therefore required a means of analysis which was sensitive to the interpretation of language to explore constructions of 'reality', which accepts the role of researcher as a dynamic influence who cannot be separated in the interaction of creating 'reality' and meaning.

2.9 Upholding Quality

It has been recognised that using evaluation criteria accepted for establishing quality in quantitative methodologies, such as reliability and validity, to qualitative studies is meaningless and contradictory to the epistemological assumptions of the methodologies (Reicher, 2000). Reflecting the variety of epistemologies used within the qualitative paradigm, a variety of frameworks

have been developed to appraise the quality of qualitative research, with no single unifying measure for quality (Madill, Jordan & Shirley, 2000).

Proposed procedures to ensure quality in qualitative research have included audit trails, triangulation, member checking and reflexivity (Cresswell & Miller, 2000; Lincoln & Guba, 1985). Alternate criteria suggested by Yardley (2000) have been outlined as sensitivity to context; commitment and rigor; transparency and coherence; and impact and importance.

This study's epistemology was grounded in the social constructionist paradigm, which proposes that multiple, equally valid realities exist and that data may produce different interpretations. For these reasons, triangulation and member checking were not deemed appropriate standards to use for evaluating the study. This does not however, sanction 'any interpretation' (Madill, Jordan & Shirley, 2000 p. 13) of the data either and an audit trail, sensitivity to context; commitment and rigor; transparency and coherence; and impact and importance. Underpinning these criteria, researcher reflexivity is considered as a process which runs throughout the current study.

Audit trails - Maintaining careful documentation and tracking the steps of the analysis process is important for increasing trustworthiness. A research diary was maintained throughout the research to track the research and analysis process. The researcher followed Braun and Clarke's six stage procedure for analysing the data set and reflections, interpretations of the data, ideas which led to theme development were recorded in the diary. Regular supervision with a research tutor experienced in TA, allowed indicating whether my interpretation of latent themes could be followed by someone else. Given the epistemological position of the study, it was not assumed that another researcher would provide the same analysis (Harper, 1999), but rather that the steps in the analysis could be followed, traced and linked back to the data.

Sensitivity to context – This was achieved by not only giving consideration and awareness to previous literature, research and ethical issues, but additionally holding in mind philosophical ideas of power, control and the

context of the secure hospital. This sensitivity was demonstrated in particular during the interviews, with the interviewer adopting a facilitative, non-challenging approach.

Commitment and rigour – These concepts were identified in relation to the research aim, with recruitment aiming to represent a homogenous sample as possible. In addition, the methods employed in data collection and analysis was consistent with stages outlined with TA. The concept of rigour overlaps with the maintenance of an audit trail and aiming for a transparent and coherent process of analysis.

Transparency and coherence - Transparency and coherence was aimed for by recognising the researcher's subjectivity and influence throughout the research process, by maintaining a reflective diary and audit trail to consider how this impacted on the final findings. The final results were linked to quotations taken from the data, to demonstrate the analysis process and final interpretations made by the researcher.

Impact and importance – This area of the research is considered throughout the discussion section, to understand how the findings from this study impact upon and add to the current knowledge base.

Reflexivity – In qualitative research there is recognition that the researcher's background, experiences, and biases will have an impact on the research process (Curtin & Fossey, 2007). For this reason, it is important for researchers to state their position and allow readers some understanding of the influence of researcher subjectivity. This is of central importance to the social constructionist perspective of the study, which understands that the researcher is integral to the process of 'constructing' knowledge.

3.0 Extended Results

The results presented a variety of narratives about the individuals who have been transferred to the high secure hospital, with four main themes were constructed from participants' experiences. These were identified as *Shifting Identities*, *Understanding and Negotiating the System*, *Engaging with Therapy* and finally and *Making Sense of Time*. This section presents the themes of *Engaging with Therapy* and *Making Sense of Time* that are not presented in the main journal paper. These themes reflected less dominant aspects of the men's experiences. Both these themes consisted of smaller subthemes, which demonstrated the different dimensions of the themes. As main themes and subthemes overlap and connect, there will be instances where one quotation may be used to illustrate several themes.

3.1 Engaging with Therapy

Participants expressed a unified understanding that their rehabilitation pathway required them to engage with the therapies. This was represented as having two distinct elements: the first was conceptualised as a personal process, *The key to personal change* and the second subtheme was conceptualised as a journey out of the System and represented in *The key to freedom?*

The Key to Personal Change

Most participants stated that they perceived themselves to be effectively engaged in therapy. This experience appeared to be validated through the supportive relationships they had formed.

Paul/114: The help I've had, everywhere I've been I've never really got that much help from people until I came here.

Ed/92: they just offered me support in the form of any time you need to speak to anybody really, then find us, if I'm not on duty then this person will be.

Steve/306: In this place you can be yourself and people accept you for who you are...in here people support you

All participants articulated therapy as a process which facilitated understanding and change. Although each participant referred to change, this was conveyed as differing individual processes. Some described therapy as a powerful tool for increasing understanding and comprehension into the development and maintenance of their difficulties. This was identified by some by the links between their early experiences and their present selves. Ben and Adrian described gaining personal meaning and achieving a sense of clarity through the process of therapy:

Adrian/56: every therapy I've done, I get so far through it and it just clicks....it suddenly turns around and you think, yeah, I'm alright I can see how things are different

Ben/190: it's about exploring myself and the reasons why I've done things, it's like epiphany, one day you just see it and it's like Wow

Others articulated that personal change through therapy, facilitated personal growth through the ability to be insightful or develop control:

Sam/106: I think also it gives you a lot of insight as well into yourself, it makes you take a good look at yourself and I think some of it's quite frightening....I've got a lot of insight now, I'm insightful, like I said I know more about myself now than I ever did...

Mark/64:It's like being here and doing all the therapies, I've got control of my life now, I've got control of what happens to me

The above accounts suggest that participants' perceived therapy as the main vehicle which helped them develop skills such as 'insight' and 'control'.

Furthermore, participants appeared to adopt the language of psychological therapy in order to understand and gain insight to themselves. This appears to have given some an effective new framework ('schemas') to provide understanding of themselves. The absorbing of psychological discourses into everyday language reflects the dominance of psychological discourse and highlights the intrinsic power issues of being engaged in therapy.

James/48: I'm doing the schema course that's coming to an end now so that has been interesting, you learn different things that you never knew before, I never knew about schemas until I came here, so it's been a good learning curve

Sam/72: I've actually got the tools to deal with when my schemas are activated....so I know how to deal with it.

Paul/22: ...to show them that I care and love for them, schema was very, very important in that

The identified changes perceived by participants helped them construct an understanding of the role of therapy as being given a second chance, which helped them imagine a possibility beyond the system:

Chris/46: I have to be happy with what I've got and I'm glad I've been given a second chance, so I just wanted to show the system that people can change if they're given the right support

Ben/23: I've been given a second chance and I've took it with both hands.

Others shared dreams and hopes about progressing to a life outside the system:

Adrian/106: I came to a point, I think halfway through VRP, when I was thinking after I've done this, that's me finished here and I was like whoa, this might be a reality this, you might get what you achieve, you might get out

Chris/34: I thought I want some freedom...there's a hope for one day I will be given a chance

Ben/181: I don't think I'll be here too long before I get moved on. I'm getting prepared for release and things like that

Key to Freedom?

This subtheme highlighted the tension between participants' sense of being engaged effectively in therapy and the uncertainty of the end point of their sentence. Although some participants could see the intrinsic value in what they were doing (as highlighted by the above theme), others appeared to be primarily motivated by a desire to do what was required to "get out."

Although participants communicated a range of views about what they thought was required for progression and eventual release, everybody recognised that in order to progress through and exit the system successful engagement in therapy was seen as a given:

Joe/210: You don't have to do it, but if you don't do it you can't get out

Most men measured progression explicitly through the number of courses they had completed or had left to complete:

Adrian/46: I've done FMMG [Forward Motion Motivational Group] over on the MI [mental illness] side so because I'd done that it meant I didn't have to do the Introduction to Group Work, so I just went on the men talking, DBT [dialectical behaviour therapy], substance misuse, schema and I've just finished VRP [violence reduction programme]

Sam/64: I've now got to do offence-related work to try and get my risk down... hopefully when I've done my VRP and my violent offending work and then discuss my index offences with my psychologist, there's a possibility I could go to an RSU

Ed/110: I'm doing all the courses in an effort to get out

Joe/82: I've got loads of courses I need to do, I'm only doing DBT [dialectical behaviour therapy] now.

In addition to the therapy programmes Sam reports additional steps that have been recommended to him ("I've now got to do"), suggesting perceived consultation rather than collaboration to facilitate progress (e.g. "discussing my index offences with my psychologist").

Although everybody could identify the mechanisms (therapy) demanded by the system to progress, with most men describing some benefits of their therapy programmes, most men also described a sense of discrepancy between their

own experience of progression through the therapy and the obscurity of a release date from the secure hospital:

Mark/66: Well they just keep saying that I've got like coursework to do, well you can go on forever more doing coursework can't you, it's never ending

Adrian/156: They wriggle and they squirm and [they say] we can't tell you, we don't know, it doesn't matter, time's almost irrelevant, it doesn't matter how long it takes it's going to take as long as it takes.

Mark and Adrian's accounts indicate that compliance doesn't always guarantee progression and indicates a level of frustration at failing to advance despite doing what they think is required. Additionally, Mark and Adrian's narratives do not indicate that they consider themselves to be at the centre of the decision making about their treatment and indicate that they are being 'told' what to do. Furthermore, Mark also indicates that the staff in his care team 'don't know' his rehabilitation trajectory, which may lead him to feel a heightened sense of powerlessness.

Alongside successful completion the therapy programmes, Sam and Chris acknowledged the expectation of the system to accept a level of responsibility about their actions in order to progress through. Whilst it is important to acknowledge the sincerity of their comments, it is important to recognise that much of the treatment aims focusses on understanding offending behaviour. Indeed this is concept that is embedded in the basic principles of rehabilitation and is an expectation which must be met in order to secure release.

Sam/50 – as human beings we all have choices and it's the choices that we make from day-today that makes us who we are as human beings....I chose to commit that crime, nobody forced me to do it, whether the system encouraged it that's not the point, I still had that choice. Now I see that, I can think about moving on.

Chris/140: if you accept the blame and take responsibility, then you move on in life and become a man....and be true to yourself.

3.2 Making Sense of Time

All participants noticed time as an integral element linked to their experience of being detained. This theme provided a constant backdrop to the participants' experience in the system. Interestingly, direct references to time were not frequently mentioned, but suggested through temporal narratives which gave the suggestion of the experience of time passing. The timescales which were referred to consisted of both measurable, chronological time ('days', 'weeks', 'years'), and widely shared, socially experienced time ('halfway through VRP' or 'when I first came here').

Within this theme participants identified two main aspects of time, which were conceptualised as the subthemes of *Everyday Time* and *Endless Time*.

Everyday Time

Most participants discussed managing time by using standard units, such as days or weeks. This allowed them to break time into governable chunks, giving participants a timetable or diary to focus upon:

Ben/61: my week consists of going down to graphics five sessions a week, ... I go down there every Tuesday, all day Tuesday, all day Thursday and Friday afternoons and then in between ... I go to the gym Monday morning, Monday afternoon we have ... ward round with all the doctors, ... I tend to go to horticulture on a Wednesday morning, gardening and all that, Wednesday afternoon I do education, mainly because I want to learn my maths ... then on a Friday I tend to have my psychology, then shopping, get your shopping done, then at weekends just chill out, go for a walk

Mark/40: Well Monday all day and Tuesday all day I go to work, Thursday morning and Friday morning I go to woodwork, Wednesday is education in the morning and all the rest of the time when I'm not working I'll be at [Name of Occupational Therapy and Education department].

Alongside a timetable, a few participants stated that 'taking each day as it comes' (Sam/102) was also a useful way of managing the days. This suggests that although time is divided into its measurable units, participants can identify some action and intention to manage 'each day'. A few participants identified

that in order to manage time, distraction was also effective. These ways of managing time in the present moment indicates a present orientated time perspective.

Mark/60: I just keep busy all the time and that probably takes it away not thinking about things

However, despite finding ways to manage time, some participants identified that the passing of time could not be avoided and this was signified by getting older:

Joe/142: I was nineteen when I came in, I'm twenty-nine now, missed all my twenties.

Mark/242: It's been just over twenty-nine years locked up and with getting older you don't know how long you've got left and all that

These accounts suggest the loss of time through the passing of the men's lives, marked by getting older. This preoccupation with time was further explored through the description of the endless time. Participants described the dragging of time and strategies for filling it.

Endless Time

Whilst men described ways of managing time, their stories also highlighted how time felt drawn out. The idea of endless time was captured by all participants identifying that a paradox existed between moving through the system, and the end point which appeared to be intangible and fluid.

Joe/78: they say do this course, do that course, that's all they say, do this course, do that course, keep your head down, see what happens from there

The lack of a defined endpoint led participants to mention their difficulties in not knowing when their detention would end. Joe talked about emotional "frustrations" (/97) whilst Paul described "mental torture" (/258) frequently. In contrast, many described not knowing when they would move on as "too difficult" to conceptualise and were unable to find the words.

Sam/94: I don't know really, I don't know, I can't answer that one

Steve/119: I don't like to think about it

For Ed, the passing of time was not only marked by the features already described, but also by a sense of alienation. This presented through his descriptions of being been dislocated from the changes in society, whilst holding the possibility he may be return to a different world from the one he left. Ed identifies that he has missed common socially experienced events which connects others:

Ed/106: we still had communism, Germany still had the Berlin wall, there was still the CCCP, the Soviet Union, all of those things, all of that ended up getting blown away and I think well in terms of the memories that I have and the world's moved on. I'm not trying to suggest that I'm sat in a little box in here and I don't have the ability to relate to what's going on through what I see on TV and reading the papers, I do, it's just that I don't share the memories of living a normal life while this stuff's going on in the background and it's a little different if you're detached from it

Despite the idea of no clear ending to their detainment, participants were able to conceptualise an existence and future outside of the secure hospital. Most men described hopes and ambitions they wished to follow, a time conceptualised simply as beyond their at the secure hospital:

Steve/128: I don't need riches I'm happy with having my faith, having hope, having a little flat somewhere, get a little job, that's what I ask for, not much.

4.0 Extended Discussion

It has been recognised that there is a lack of research considering the subjective experiences of those detained in forensic services (Coffey, 2006). Previous research has been rooted in the positivist paradigm which often predetermines the results obtained to categories defined by the very tools that are used to measure experience and opinion. Previous studies have aimed to understand concepts of quality of life, autonomy, control, self-esteem, engagement (Blatier, 2000; Camfield & Skevington, 2008; Ferguson, Conway, Endersby, & MacLeod, 2009; McCarthy & Duggan, 2010)

This study is designed to capture the individual perspectives of a distinctive group of forensic service users – those who have been transferred from prison and been detained longer than their original sentence for treatment and rehabilitation purposes. They denote a unique group of individuals whose experiences have never been captured.

The men's narratives indicate that their subjective experiences are strongly shaped by macro-level social and structural factors. The results imply that the mechanisms of power and the social processes in place to manage mental health problems, such as policy and models of service delivery, has a significant impact on the experiences of rehabilitation in high secure hospitals.

4.1 Identity

Whilst there has been a recent shift towards the deinstitutionalisation of mental health care, high secure hospitals remain examples of Total Institutions (Goffman, 1961) in UK health provision. Although it has been 50 years since Goffman's commentary on life in an asylum, participants in this study described similar features present in their experience of life in the secure hospital. Of note was Mark's description of entering the secure hospital, the confiscation of his possessions on arrival, and the feeling that he had become more "dangerous". This experience is disturbingly similar to Goffman's description of the "Mortification of the Self" and the stripping of one's identity, with a new identity being defined by the social processes of the institution (Goffman, 1961). The process described by Goffman is comparable to the symbolic interactionist perspective in psychology, which recognises the importance of the reciprocal

relationship between social structure and identity (Mead, 1934). Identity theory (Stryker, 1968, 1980) suggests that concepts of the self are not a single autonomous entity, but people are a multifaceted social construct, where a person's identity emerges through social interaction. Stryker (1968; 1980) proposed that an individual can hold multiple internalised components of self known as 'role identities' (such as *mother*, *daughter*, *teacher*) which represent the positions that individuals occupy within various social contexts. Identity is therefore a critical link between a person and social structure, because identities are categorisations people make about themselves in relation to their location in social structures. Role identities are theorised to be organised into a *salience hierarchy*, with identities high in the hierarchy being more likely to be implemented than those lower in the hierarchy. The salience hierarchy determines which identities are implemented by people as they assume their roles through the interpretation of the behaviours of others. In short, people tend to know who they are in terms of their interactions with others (Mead, 1934). In the context of this study, it can be assumed that the men hold multiple role identities in their lives, with many referring to roles as *father*, *son* as well as *patient*. However by being transferred to secure hospital, the role most salient becomes that of *patient* as all interactions with others is predicated on this position. For example, the role of *patient* takes on meaning in relation to the role of *psychiatrist* which will be connected to the role of a *nurse* and it is the responses by others which form the basis of self-definition and the identity assumed (Hogg, Terry, White, 1995).

4.2 Power

In addition to the consideration of identity theory, the position of *patient* assumed by the men detained can be interpreted through the multi-dimensional processes through which Lukes (1974) and Foucault (1979) conceptualise the mechanisms of power. The very idea of diverting offenders with mental health problems away from the CJS and providing treatment challenges traditional ideas of retribution for criminals. The process has the benefit of identifying the role of the state to that of redemption and the role of the offender to that of *patient*. Whilst diversion from prison shifts the focus from justice in society to concentrate more on rehabilitation, it also determines the position of the state as benevolent towards those with mental health problems. As attention has

been drawn towards this morality both through policy, at a national level, and international human rights laws, it might appear that the first dimension of power (Lukes, 1974) has constructed a position where offenders with mental health problems have been absorbed into a transparent operationalised decision making process.

In the second dimension of power, the overarching idea of treatment appears to be the rehabilitation process of being 'safe' and 'well enough' to return to society. This was highlighted by the narratives of the men who identified that they 'needed to lower their risk', resulting on a focus on risk management and containment. This notion central to the provision of rehabilitation services, then may not permit alternative models of rehabilitation, such as those adopted in Scandinavian countries (e.g. open prisons where those detained are able to be more autonomous) to be considered. Finally, whilst there are contemporary challenges to the validity of constructs of mental illness (Coles, Keenan, Diamond, 2012) the dominant medical discourse still presents these as relatively uncontentious. Therefore the third dimension of power continues to present a discourse steeped in the language of illness, thereby silencing the arguments presenting mental illness as a socially constructed subjective phenomena. Thus the power imbalance between the psychiatric patient and the professional expert continues to be maintained through the use of language (Burr, 1995; Foucault, 1979). This was identified through the significance of medical and psychological language used by the men throughout their interviews. Their references to "diagnosis", "schemas", "behaviours" as well as "risk" shows their assimilation of the more dominant discourses.

Given that the all three dimensions of power in today's society establish those transferred to high secure hospitals as a *psychiatric patient*, it is perhaps unsurprising that this was the common strand of experience which shaped the men's narratives. In terms of recent ambitions to provide patient-centred mental health care it could be argued that introducing the principles of true patient-centred care in the context of the processes of power is challenging. Any attempt to promote purposeful adoption of patient-centred care demands that institutional power be yielded on all three dimensions. Promotion of patient centred care in the context of forensic mental health services demands, not only the development of positive relationships, but also the transference of real

decision making power to those detained (Masterson & Owen, 2006, Vassilev & Pilgrim, 2007). It is worth considering that any effort to promote change to the position of those receiving care would also demand a fundamental change at the third face of power, language. Without a shift in the disempowering medico-psychological discourse surrounding mental health problems, endeavours to create a real partnership between those transferred and detained in forensic services will be unattainable.

4.3 The Position of Therapy

Whilst mental health policies (DoH, 2011) have highlighted the importance of providing patient centred care, consideration must be given to the role of the secure hospital to not just provide treatment but to rehabilitate individuals back to society. It is worth noting that the function of rehabilitation is different to that of therapy, although the two are linked. Traditionally therapy is the vehicle which supports individuals to improve their wellbeing, manage symptoms and gain understanding and insight (Wampold, 2013). These notions are complicated by the requirement of the secure hospital to also manage risk. That is not to say that therapy cannot support risk management, but one needs to bear in mind the complexities of *rehabilitation* (as oppose to *treatment*) create additional requirements of citizenship, which has unfortunately not been within the scope of this thesis to explore further. Conversely, the participants of this study recognised the role of therapy as implicitly connected to their rehabilitation pathway and a means to exit the System. Those who talked about complying with therapy and perceiving positive engagement identified that it had fostered self acceptance, personal growth, development and positive relations with others, which are all defined elements of personal wellbeing (Ryff, 1989). Interestingly, aspects of wellbeing which were not mentioned were those related directly to environmental mastery and purpose in life. This absence suggests that there is difficulty in fostering these elements of wellbeing given treatment delivered within contexts of highly controlled environments (The Sainsbury Centre for Mental Health, 2009). In addition, participants spoke about being able to achieve modest life goals (a home, a dog, a little job somewhere) following a return to society. This indicates that engaging with the therapies also fostered qualities such as hope and self-acceptance, which are seen to be

important aspects of personal recovery which support processes of adjustment (Yanos, Roe, & Lysaker, 2010).

Clearly, therapy was a valuable experience for a number of participants. However, all participants recognised it was mandatory and some found it less useful than others. Whilst some individuals experienced personal gains, there was an overarching sense that men engaged in therapy to 'get out', reflecting some of the debate and findings in the current literature about the efficacy of mandated treatment (Mezey & Eastman, 2009; Mezey, Kavuma, Turton, Demetriou, & Wright, 2010).

This impression of the men's engagement in therapy was further cemented by the descriptions men gave of their progress through the care pathway through descriptions of the numbers of courses they had completed or had left to complete. This not only reinforced the impression that men 'were going through the motions', but also suggested that everyone that is detained in the high secure hospital, follows an existing programme, rather than interventions being individually tailored to meet personal needs. If this is the case, this would give further explanation to the descriptions by participants about being 'told' what to do, rather than being collaborated with on an individual basis. It was not made clear in the interviews how the care pathways are created and staff at the hospital may feel that they collaborate with the men in conceptualising treatment aims. However if the therapy programme is predetermined and fixed, it raises questions to how meaningful efforts to collaborate with the men can be. The creation of mutually agreed aims is seen to be a core factor in positive outcomes and satisfaction of therapy (Wampold, 2013). In order to foster this, anyone undertaking any therapy needs to part of the decision making process. Studies have shown that mutual aims can be agreed for participants undertaking group programmes, so again, the details of how this is introduced in the setting of this hospital may have to be reconsidered.

One of the important aspects shown in the results was that when the men talked about their experience of therapy, they did so largely within the context of supportive relationships with staff. Research into the effective mechanisms of therapy often indicates that good therapeutic alliance is a fundamental factor in both community and forensic mental health treatment outcomes (Hansson,

Bjorkman, Priebe, 2007; Sorgaard, 2007). Research into the importance of therapeutic alliance has shown that the relationship itself can be the main factor influencing change (Leach, 2005). In addition a meta-analysis (Messer & Wampold, 2002; Wampold, 2013) indicated that common factors in therapy were the active ingredients, not specific therapy models. This vital component of therapy should ideally be advocated when delivering therapy to individuals who are seen to be difficult to engage and risky. Conversely, whilst participants in this study described feeling supported and understood by their relationships with staff, it is impossible to identify the influence of the context of the researcher in producing these statements. It should be noted that the interviewer holds the title of 'trainee clinical psychologist'. Although efforts were taken to reassure participants that their interview data would be anonymised, there care team would not know about the content of the interviews, and they would not be identified, it is possible that the narratives about supportive relationships were the product of the context. This is a particularly salient consideration in relation to the accounts that participants' relayed about being watched and evaluated by the system.

Considering the temporal aspect in the men's detention, their experiences pointed out that the men had created mechanisms to manage their time in the secure hospital, despite being conscious of the fact that they had no fixed release date. It appears that the secure hospital's pre-existing rehabilitation pathway, allowed the men to identify some progression through mapping their stay against completion of therapy programmes. The very sequencing of the programmes appeared to serve the function of providing goals or marking achievements for individuals, whether that be by day, a week or until the end of a course of therapy. This way of organising and managing our subjective experiences has been outlined in research which investigates time perspectives (Zimbardo & Boyd, 1999). The participants' accounts reveal that the men appear to use the 'chunking' of time into manageable units to manage the indeterminate nature of their stay. Whilst their release date is intangible, they appear to switch between a 'present' focussed time perspective and a 'future' orientated one (Zimbardo & Boyd, 1999). Whilst a concrete fixed release date is not available to those detained past their original sentence, the function of treatment is to rehabilitate individuals back to society. It could be proposed that

participants' daily encounters with the hospital and staff, such as therapy programmes and CPAs, operate to work towards the goal of release. It appears that it is this very promise of a 'future', and not the concrete setting of a release date, which provides individuals with a mechanism to set goals and imagine a future beyond the secure hospital.

This setting of goals could be linked to psychological concepts of self efficacy in that individuals are able to exercise influence over their own behaviour (Bandura, 1977). Self efficacy beliefs are seen to be the most central influence on the choices people make, their goals and the amount of effort they apply to a task and how long they persevere if facing failure or challenges. It appeared that those participants who connected their involvement and completion of therapy programmes to a sense of progression through the system, described greater levels of self efficacy and satisfaction, allowing individuals to foster hope for the future. Indeed the very achievement of progressing through a course and onto the next will serve the function of increasing one's beliefs that they have the ability to effectively complete the next course. The ability to focus on the future has been noted to be another aspect of well-being and positive functioning allowing for hope to be fostered (Boniwell, 2005).

4.4 Implications for Practice

This study has highlighted the inherent power mechanisms at play in the diversion and treatment of offenders with mental health problems. The requirement for risk management and containment of this population is set out by mental health law, whilst ideals about what is required to be determined 'safe' and 'well' to return to society determined by the criminal justice system. These processes situate the participants who took part in this study in an inherently less powerful position. Whilst it is important to recognise this context of those transferred and detained indeterminately, there are some modifications to everyday clinical practice which may be useful to consider.

At a fundamental level the positions of clinical psychologist may be key in introducing and integrating a more holistic approach to care. The function of psychological formulation, which allows for the consideration and integration of biopsychosocial understandings of symptoms and behaviour, appears to be paramount in order to move away from the biomedical understanding of mental

health problems. Clinicians would have to be mindful that this role did not simply replace a medical discourse with that of psychology, but instead integrated the language of those detained in order to promote a shift away from powerful dominant discourses. This would perhaps help to work towards diffusing the power at Lukes third dimension, language. It has been recognised that systemic and narrative approaches can help shape language used by a system also how mental health difficulties are conceptualised (Adshead, 2014). Whilst a radical overhaul in the way that mental health difficulties are understood may go beyond the scope of the profession in the short term, by promoting different narratives and presenting more holistic ways of conceptualising a person, such as through formulation meetings, could support a more collaborative way of working with individuals.

The men in the study highlighted the experience of transfer and adoption of the role of patient as a significant part of their experience. Whilst it may not be possible to alter this process, support could be given to help individuals understand their transfer through improved mechanisms of communication. This may then help to diffuse the stigma and mystery about secure services.

The importance of engaging individuals effectively in processes of care planning has been highlighted by this study. Whilst individuals were able to identify mechanisms for planning their care and setting therapeutic goals, such as care programme approach (CPA) meetings and ward rounds, there appeared to be a lack of collaborative goal setting experiences identified in the descriptions of therapy in the interviews. As noted earlier, being involved in one's care is not only important for engagement, but also for promoting a sense of control and increasing a sense of autonomy (Ryff, 1984; Wampold, 2014). Furthermore, current UK policy (DoH, 2011) expects involvement and collaboration with service users within any therapeutic relationship. However, this study indicted clear power imbalances present for those involved in high secure hospitals. This drive towards increasing choice and empowerment in mental health services may be difficult to reconcile within high secure settings, perhaps highlighting the conflicting pressures for clinicians when working within this environment. (Adshead, 2013; 2014, Ward, 2013). Recent literature from clinicians working in forensic settings is beginning to accentuate the tensions of working in this context, bringing these issues to the foreground, with some clinicians hoping to

push towards creating an overarching and cohesive model of care, which reconciles the multiple paradoxes of working therapeutically in forensic environments (Adshead, 2013; 2014).

4.5 Limitations

Given the context (high secure hospital) of the interviews and the identified powerless position of the participants, the effect of 'performance' by participants and how this shaped the results cannot be discounted. Indeed Ed even identified that he wanted recognition that he had changed, which he hoped to demonstrate through taking part in the study:

Ed/19: I believe that I can influence the authorities in the decision making progress as far as my life is concerned and the right I have to a life. I believe I can do that, in the same way that I can do it negatively....., I believe I can do it positively, which is one of the reasons I'm taking part in this study today, I think I believe that at some point in the future if this helps to change any of the views or attitudes that are going on, which I would love to see too, for your benefit and also for my benefit and for the benefit of everybody who's in this situation, I would like to see it change some things about how life is for people in this situation. I believe that sure that positively I can influence the authorities and I try and do that every day in my own way, just by being calm and composed and behaving in a non-threatening way if possible.

This explicit 'confession' for the reason for participating by Ed cannot and should not be ignored and may indicate the underlying reason for participating in the interviews.

4.6 Future Directions

Whilst the study offered new insights to the experience of detention in a high secure hospital, the nature of this research permits only limited conclusions to be drawn. It must be recognised that participants in this study were recruited from one high secure hospital, resulting in data which was selective and representative only of this environment. There may be value in extending this study and analysis to invite others transferred to the other high secure hospitals in the UK (there are two others), to understand whether similar issues emerge. This would allow us to understand whether the themes captured in this research

are indicative of the processes of transfer or maybe more representative of the specific secure hospital.

It is worth considering that the men in this study stated very clearly that they felt that they were constantly monitored and evaluated, which may have impacted on the content of the interviews. A study involving men who have achieved transfer out of the system to medium secure hospital or Regional Secure Unit (which the majority of men in this study indicated they were aiming for), could offer different retrospective insights into their experience of transfer to high secure rehabilitation. A collection of narratives mapping individual experiences throughout the process of rehabilitation would give greater understanding of the journey through the forensic rehabilitation pathway, allowing aims and delivery of forensic of services, and potentially policy initiatives, to be tailored to best meet the needs of this complex population.

Whilst this study aimed to give voice to those detained in high secure hospitals, it is recognised that the research was conceptualised by a trainee clinical psychologist, who inherently holds more power due to the professional hierarchies. In order to minimise the power differential that this research created, adopting a position to collaborate with those detained in conceptualising the research could work towards minimising this. This way of creating research aims is known as *Participatory* research and aims to bring the knowledge of participants into the foreground. This type of research recognises the mechanisms of power in the research process and challenges this by inviting participation of those being researched. In short the *researched* become the *researchers* to some extent. This way of conceptualising research comes from feminist theory (Pitt *et al.*, 2007) allowing participants to control all aspects of the research process, so different and relevant results for the population studied are obtained (Pitt *et al.*, 2007) as the shared positions of the interviewer and those participating minimises the power differentials (Oakley, 2004). It is thought that the unique process of this research allows for themes and concepts not otherwise apparent to emerge in both interviews and analysis (Pitt *et al.*, 2007). A study conceptualised from this perspective would no doubt offer novel insights into the experiences of those transferred and detained for treatment and rehabilitation purposes.

4.7 Conclusion

In conclusion, this study offers a unique contribution to the current literature, highlighting the links between power and service delivery for users of forensic services. A number of clinical implications are raised in particular the importance of the need to focus on the meaning of transfer to the setting and provide psychological therapy which can address the issues this raises across forensic service users experience. At a wider level, it draws attention to the impact of existing social structures, such as policy and the need to examine how this influences clinical practice. The role of clinical psychologists is highlighted to help by adopting narrative approaches in this setting in order to diffuse the inherent power differences that occur through the use of language. The use of formulation amongst staff groups may support this process. Future research is indicated incorporating a wider range of forensic service user experiences.

4.8 Critical Reflection

As this study was grounded in a social constructionist paradigm, which recognises the position of the researcher as a co-constructor of the meanings identified in the research. It was essential to engage in reflections throughout the research process, which monitored the effect of my own positions and views on the research. Two main methods were used to do help me do this. Firstly a research diary was kept throughout the process, this allowed me to reflect spontaneously and immediately on thoughts and feelings which arose at various stages of the process. In addition, particularly useful vehicle for reflecting was regular supervision with my field supervisor. This had the distinct advantage of exploring issues with a clinician who had an extensive and intimate knowledge of the particular issues of the complexities of working both with a forensic population and the setting itself.

At the outset, although excited by the conceptualisation of my research aim, I found myself being preoccupied with the particulars of going into a high secure hospital. This consisted of being unsure of conflicting preconceptions, such as that the men I was hoping to interview were known as being acutely unwell, as well as potentially dangerous. Before my first visit to the high secure hospital I wrote:

I'm really worried about tomorrow after the Induction. Franco's really scared me about how to manage myself on the ward and the possible threats of working there. Try and hold on to what Louise has told you – that these are poorly, vulnerable men and I have the skills to be kind and empathic. You're only going to look at the files tomorrow – you'll be fine!!!

The early stages of being at the high secure hospital were particularly difficult and I found myself absorbed into the mechanisms of the organisation. Recruitment took much longer than anticipated and I found myself getting frustrated:

Ahhhhhhh, another day spent at I haven't heard anything from the RCs!! 3 weeks in and still no replies and I've done everything the secretaries have told me to. I'm going to have to find a way to go in more often, to push this on, but I'm sick of this, it's such a long drive for nothing!!!.....It makes me think, that if it's like this for staff, what's it like for the patients?!?!'

Once the recruitment process got underway, I was acutely aware of the dynamics of the surroundings. This was realised during my first visit to a ward, when I was shown around and met a potential participant for the first time:

Going down to the ward was strange today – not knowing what to do, being shown around and being watched by everyone (patients and staff). I wonder what it feels like for a patient when they first get here? I felt really awkward and it was weird. Mind you, the guy was nice – really hope he says yes!

Following my first interview, there was an element of surprise at the content:

I'm surprised at what was said today during the interview. He didn't talk about the things I expected. I've just realised how differently about this I was thinking and today's just told me how different staying at..... is for this man.

A few interviews on, I began to identify that participants were talking about existential ideas during their interviews:

Roshan was right about the existential stuff.....The interviews are definitely making me think about being free in yourself versus literally free.

About halfway through the interview process, it is interesting to note that I recognised how I felt comfortable in the environment:

Going toisn't so bad. It's amazing how quickly I've found my stride. Going back to my earlier thoughts, I wonder how much this may reflect the men's experiences of being there? The ones who have talked about it being ok being there – I wonder if I've just settled into being there, a bit like them?'

On reflection, I recognised that my early interviews were with men who had been open and positive about their stay in secure hospital. And some of my ease of being there was a reflection of how comfortable I had felt in the presence of the participants. I had by this point, had become absorbed into the organisation, which for the most part seemed benign and safe. This was a position that was challenged during the next two interviews:

Hmmm, do I need to talk to Louise? I feel really uncomfortable following that interview – I now know what Louise means by 'very unwell'! I wonder how much of that interview was useful? What was said today was really different to the other interviews and it seems like he is in a very different place to the men on the PD wards.

Ahhh, another man who seems unwell and a bit paranoid. But is he paranoid? Or is he really actually unsafe back out there? He definitely feels safer in here and he's the first person that's talked about that.

As I came to the end of the interviews, I reflected on the differences between the people who seemed more unwell on the mental health side compared to the personality directorate men:

I wonder how the interviews will come out when I read the transcriptions? It feels like the men from the PD wards said similar good things, whilst it seems that the men from the MH wards had really different experiences....

At the beginning of analysis, initial coding seemed like lots of disparate ideas had been talked about. Following coding of the first two interviews, I could not imagine how the initial codes would come together, however after coding about half, some patterns started to emerge. And once all eleven had been coded, I had some clearer ideas about initial themes. This was followed by a research

supervision session, where we identified the themes and constructed a thematic map:

I'm so pleased with today, I feel like I know where I'm going with it – it's amazing that it's come out like a journey. I'm surprised that therapy was such a key thing in it....

Having been excited about the superordinate themes, I reflected upon how I was going to make sense of the data and met with my field supervisor to think about what the themes meant for the men:

Meeting with Louise today was useful. Remember that this seems to be more about general principles of wellbeing and recovery, than 'not knowing' is not the only issue for these men, it seems to be more about making meaning and being there.

This research process has been a huge learning a development curve for me. On one level I feel like I have also been on a personal journey through the system, however brief and detached. Having had no experience of high secure hospitals prior to this research, encountering the hospital for the first time, I carried the preconceptions of not only the organisation but the people in it. Through the process of the interviews, I have shifted to the same position as my field supervisor in holding in mind, despite what offence may have been committed, I see the people detained in secure services as potentially some of the most vulnerable and damaged by our society. As a clinician, it has been invaluable to be able to shift my position and see the personal resilience and seeing the potential for change in those deemed unacceptable by society.

5.0 References: Extended Paper

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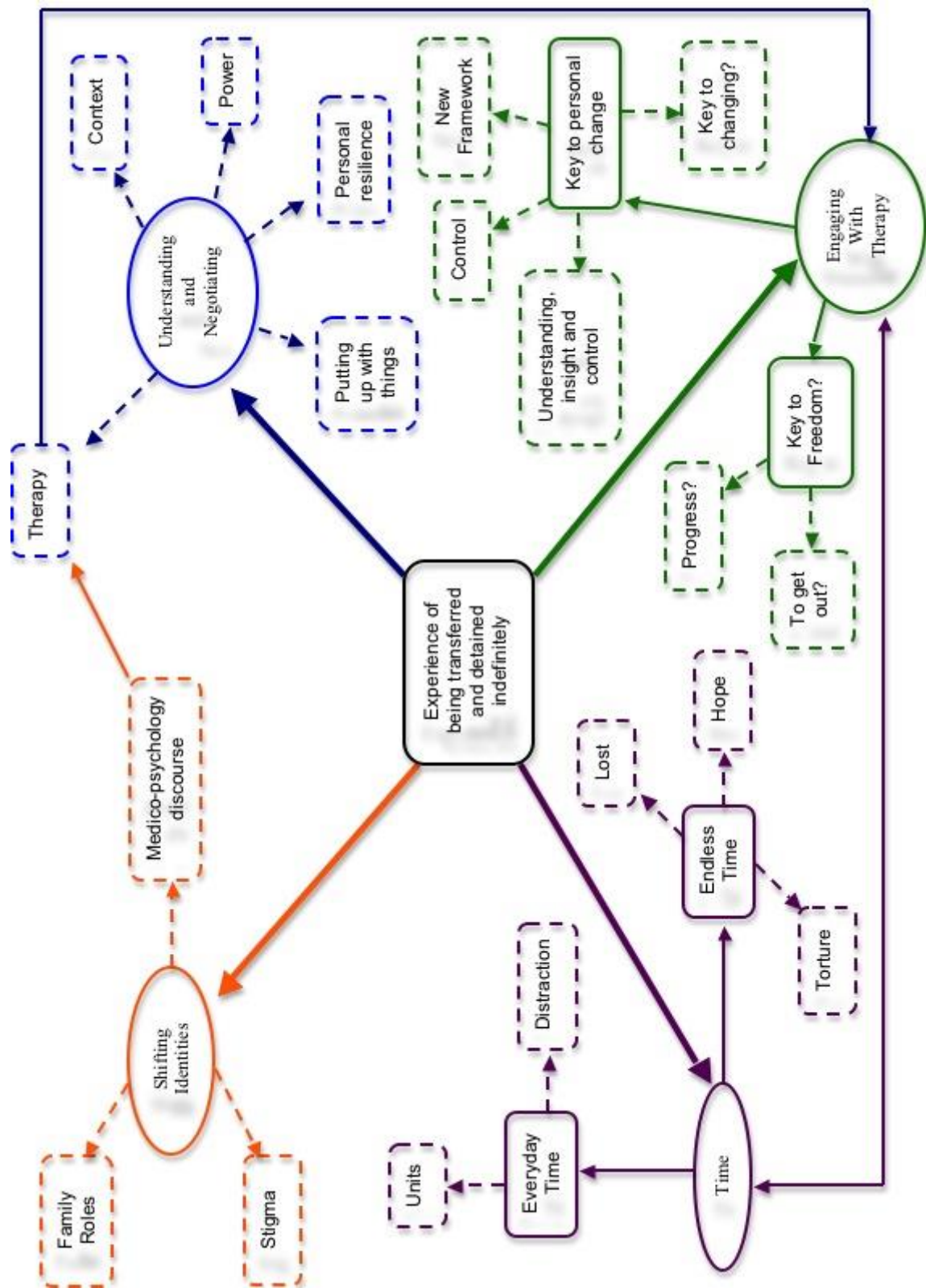
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Appendices

Appendix A: Thematic Map



Appendix B: Interview Schedule

The Impact of an Unknown Release Date on Psychological Wellbeing

Interview Agenda

Below are the areas to be covered in the semi-structured interview. These areas will be approached in a flexible way during the interview, in a manner which is understandable to the participant and incorporates the views of the participant.

- How they feel about their transfer to secure services? (What they felt, how they have adjusted, what it meant in terms of how they pictured their mental health)
- How has 'not knowing' affected you?
- Do you think that 'not knowing' has had an impact on them and if so, what kind of effects might it have had?
- How do they feel about being in secure services?
- What do you understand by the term 'wellbeing'?
- How do they feel that the term 'wellbeing' applies to their own experiences of mental health problems
- Do they think that there are any links between 'not knowing' and your wellbeing?
- How do they cope with their situation?
- How do they cope with the indeterminacy of their stay?
 - o In terms of 'not knowing' when they will be released
 - o How does this impact their psychological wellbeing?

'Psychological Wellbeing' will be explored in terms of understanding how someone constructs their own psychological wellbeing. Traditional notions of wellbeing will be explored to do this, such as self-acceptance, positive relations with others, autonomy, environmental mastery, purpose in life and personal growth.

Appendix C: Ethical Approval



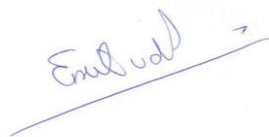
Lincoln, 23-2-2012

Dear Sunita Guha,

The Ethics Committee of the School of Psychology would like to inform you that your project on "The impact of an unknown release date on the psychological wellbeing of people transferred from prison services to a high secure hospital" is:

- ☐ **approved**
- ☐ **approved subject to the following conditions:**
- ☐ **invited for resubmission, taking into account the following issues:**
- ☐ **is rejected. An appeal can be made to the Faculty Ethics Committee against this decision (cawalker@lincoln.ac.uk).**
- ☐ **is referred to the Faculty Ethics Committee. You will automatically be contacted by the chair of the Faculty Ethics Committee about further procedures.**

Yours sincerely,

A handwritten signature in blue ink that reads "Emile v d Zee" with a stylized flourish at the end.

Emile van der Zee, PhD

Chair of the Ethics Committee of the School of Psychology
University of Lincoln, Department of Psychology
Brayford Pool
Lincoln LN6 7TS
United Kingdom
telephone: +44 (0)1522 886140
fax: +44 (0)1522 886026
e-mail: evanderzee@lincoln.ac.uk
<http://www.lincoln.ac.uk/psychology/staff/683.asp>

Microsoft

Outlook Web App

sign out | Sunita Guha (10197322) -

Mail > Inbox 18 results in entire mailbox

favourites

Sunita Guha (10197322)

Inbox

Drafts

Sent Items

Deleted Items (407)

Junk E-mail

Notes

Search Folders

Mail

Calendar

Contacts

Tasks

Public Folders

New - Delete - Move - Filter - View -

Emile

Application for Ethical Approval - RESUBMISSION

03 October 2013 17:10

Hi Sunita, feel free to add a tick, my email clearly confirms approval, all my best,

Emile

Sent from my iPad

Sunita Guha (10197322)

Sent Items

03 October 2013 15:24

Hi Emile,

I have attached my ethics form which you sent to me a while back (February 2012) as I have realised that the pdf, doesn't actually highlight that the university has granted ethical approval.

This was an oversight on my behalf and as I have now submitted my thesis has been picked up by the markers. I was hoping that you could rectify this and return it to me as soon as possible, as I need to send proof to my markers.

Many thanks,
Sunni

Attachments: Sunita Guha 23-2-2012.pdf (88 KB) [Open as Web Page]

2013.01.30 12:4313 Su....rtf

Scanned Substantialpdf

Show all downloads...

05 September 2012

Miss Sunita Guha
Trainee Clinical Psychologist
Lincolnshire Partnership NHS Foundation Trust (LPFT)/ University of Lincoln
Trent Doctorate in Clinical Psychology
1st Floor, Bridge House, Brayford Pool
University of Lincoln
LN6 7TS

Dear Miss Guha

Study title: The Impact of a Unknown Release Date on the Psychological Wellbeing of People Transferred from Prison Services to a High Secure Hospital

REC reference:
IRAS Project Number:

Thank you for your letter of 05 September 2012, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Non-NHS sites

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

21 February 2013

Miss Sunita Guha
Trainee Clinical Psychologist
Lincolnshire Partnership NHS Foundation Trust (LPFT)/ University of Lincoln
Trent Doctorate in Clinical Psychology
1st Floor, Bridge House, Brayford Pool
University of Lincoln
LN6 7TS

Dear Miss Guha

Study title: The Impact of a Unknown Release Date on the Psychological Wellbeing of People Transferred from Prison Services to a High Secure Hospital

REC reference:

Amendment number:

Amendment date:

25 January 2013

IRAS project ID:

The above amendment was reviewed at the meeting of the Sub-Committee held on 21 February 2013.

Ethical opinion

The members of the Committee taking part in the review gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

Approved documents

The documents reviewed and approved at the meeting were:

Document	Version	Date
Participant Information Sheet	1.2	25 January 2013
Protocol	1.2	25 January 2013
Notice of Substantial Amendment (non-CTIMPs)	1	25 January 2013
Covering Letter		25 January 2013

Membership of the Committee

The members of the Committee who took part in the review are listed on the attached sheet.

positive



03/12/2012

Miss Sunita Guha
Lincolnshire Partnership NHS Foundation Trust
1st Floor, Bridge House
Brayford Pool
University of Lincoln
LN6 7TS

Dear Miss Guha

Study Title: The impact of an unknown release date on psychological wellbeing
LC: Dr Louise Braham
CI: Miss Sunita Guha

Recruitment target: 20

Summary: The overall aim of this study is to explore and understand the impact of an unknown release date on the psychological wellbeing of people transferred from prison services, where they will have known their release date, to a high secure hospital.

Participants will be recruited from [redacted]. The researcher will send an invitation letter and Information Sheet to all Responsible Clinicians, named psychologists/ nurses and request that they identify potential participants that may be approached by the researcher. Information about the study and a reply form will be distributed to the potential participants along with a list of drop in sessions where the researcher will be able to answer any questions and after at least 24 hours take formal consent if they wish to take part. If they are interested in taking part they will be asked to return the expression of interest reply slip to their RC who will organise attendance to the drop in's. Interviews will be arranged through the MDT to ensure that individual requirements are met and the session doesn't clash with any therapy that is currently taking place.

Thank you for submitting your project to the [redacted]



Appendix D: Information for Participants

The Impact of an Unknown Release Date on Psychological Wellbeing

Participant Information Sheet (To be printed on headed paper)

Thank you for taking time to read this information leaflet.

You have been invited to take part in a research study. The study aims to explore the factors which you feel affect your psychological wellbeing. There will be a focus upon how you are coping with the change from having a fixed date of release (in prison) to now not knowing.

This leaflet gives you some information about the study to help you decide whether or not to take part. You can also attend one of the drop-in sessions being held by the researcher, Sunita Guha, to find out more information and ask any questions. The drop-in sessions will be held on *(Location, Time and Dates)*

Participation in this study is completely voluntary and will not affect your future care.

What is the purpose of the study?

We want to find out how you are coping with the change from having a fixed sentence, in prison, to not knowing your release date and how this affects your psychological wellbeing. This will include asking questions about how you see your psychological wellbeing, how you cope currently and how you feel about the future.

Why have I been asked to take part?

Everyone who has been transferred from the Prison Service to the Mental Health Service in Rampton Hospital under the Mental Health Act and who have stayed longer than their original length of detention has been invited to participate.

Do I have to take part?

No, you do not have to take part. Deciding not to take part will not affect your care.

If you decide to take part, you have the right to withdraw at any time. Withdrawing from the research will not affect the care you receive.

What will happen to me if I take part?

Firstly, you will meet with the researcher, Sunita Guha, to fill in a consent form. This will be a time to ask any questions about anything you are unsure of and have them answered. If you are sure that you want to take part, you will be asked to fill in a Consent Form, which you will be given a copy of.

The times and dates of your interview will then be met by agreement between you, your ward and Sunita. The interview will take place at [REDACTED], on your home ward, and will last up to a maximum of 2 hours. You will be asked to answer questions about how you feel about your transfer and the factors which affect your psychological wellbeing. This will include asking you about how you cope with not having a definite release date since you have been transferred to [REDACTED]

01 September 2012

Version 1.1

Page 1 of 4

The questions asked at the interview will be about your personal experiences. Some of these topics are sensitive and could be upsetting. Please think carefully and talk to your care team about whether you want to take part in the study to discuss your experiences. Not wishing to take part in the study will not affect your care in any way.

Sometimes people find discussing their experiences difficult and distressing. If answering any of the questions in the interview leaves you feeling upset, angry or distressed and you would like to speak to someone about your thoughts and feelings you can contact several people to talk to:

- Your Named Nurse or Responsible Clinician (Name).
- You can contact [REDACTED] (*field supervisor*) (Number).

The interview will be audio recorded and your interview will be a part of the data for the study.

What happens to the information that I give?

All information collected about you will remain anonymous and confidential. This means that you cannot be recognised from any information that we keep about you, as it will not have your name on it. Instead all participants will have a code number. The code numbers will be kept in a password protected file which can only be accessed by the researchers.

The interview data will be stored in a secure and locked filing cabinet in the psychology department in the hospital.

Direct quotations from your interview may be used to support the results of the study when it is written up. These will be anonymised so that people will not be able to identify you and your participation in the study from them.

I want to take part in the study, what must I do next?

If you wish to take part in the study, please complete the slip at the end of this leaflet with your contact details and return them in the envelope to your named nurse or Responsible Clinician. Sunita will then contact you to discuss your participation and gain consent from you.

If you are not sure and would like to have an opportunity to discuss the study further, please contact Sunita Guha, in the psychology department on these (*Dates*). The contact details are given at the end of the information sheet.

What if I do not want to take part in the study?

If you do not wish to take part, you do not have to do anything further.

What if I change my mind about participating?

You are free to withdraw from the study at any time and do not have to give a reason for doing so. Changing your mind and deciding not to take part will not affect your care in anyway.

You can change your mind and withdraw from the study at any time up to one week after your interview. This would mean that the information you gave at interview will be destroyed and will not be used in the research.

If you decide to withdraw later than one week after your interview the information you gave at interview may be potentially used in the research. This is because the information you gave will have been transcribed, coded and made anonymous by this time.

What will happen to the results of the research study?

The study will be submitted to the University of Lincoln as the thesis for a Doctorate in Clinical Psychology. In addition, the results of the study will be submitted as a journal article to be published. If you wish, you can be sent a report of the final findings. Any report or publication from this study will keep information about you anonymous and confidential.

What if there is a problem?

If you have any further questions or concerns about any part of this study you can contact the researcher or her supervisor, who will do their best to answer your questions:

Sunita Guha (Researcher)

[REDACTED] Supervisor)

(Address)

(Address)

(Telephone Number)

(Telephone Number)

(Drop-in Session Dates and Times)

If you would prefer to contact someone who independent and is not a part of the research team, you can contact the Chair of the School of Psychology Ethics Committee at the University of Lincoln:

[REDACTED]

University of Lincoln, Department of Psychology
Brayford Pool
Lincoln
LN6 7TS

Telephone Number [REDACTED]

Complaints

Appendix E: Consent Form

The Impact of an Unknown Release Date on Psychological Wellbeing

Alternatively, if you want to formally complain, you can do this by using the NHS complaints procedure. Details of this can be asked for from your Responsible Clinician / Named Nurse or any member of staff working on your home ward.

Thank you for taking time to read this information sheet!

Expression of Interest

If you have read the Participant Information Sheet and are interested in taking part in this study please fill in your details below and return the slip to your Responsible Clinician / Named Nurse.

Sunita Guha, will be in contact with you to answer any remaining questions you have and to fill in a Consent Form, if you still wish to take part.

-----**(Fill in the information below, tear off and return to your RC/ Named Nurse)** -----

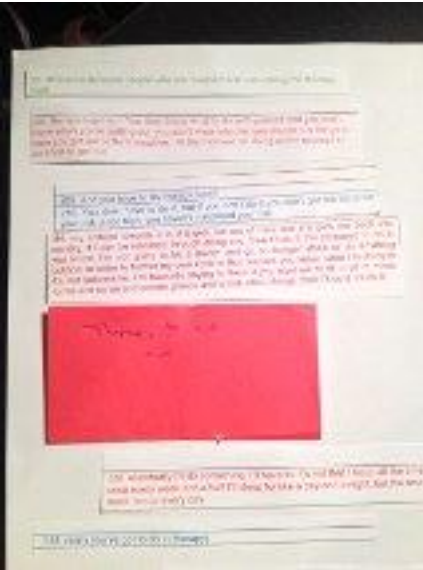
- I am interested in taking part in the study which is investigating the 'Impact of an Unknown Release Date on Psychological Wellbeing'.
- I am happy for the researcher to contact me about taking part in the study.

Signed: _____

Name: _____

Home
ward: _____

Appendix F: Initial Codes



Appendix G: Emerging Themes



Early Version of Thematic Map



Appendix H: Research Aims: A Continual Process of Change

Following my initial write up, having received detailed feedback from markers, it became clear that the initial analysis of my research was not entirely on target. I needed to refine not only my analysis but also my research aim. Lessons learnt from my initial write up consisted of recognising that enough time had not been given to my first analysis. In order to reconsider my research the main elements that I focussed on from feedback was to attempt to make analysis more latent, adopt a social constructionist perspective more strongly, and 'tighten' my research question. I felt that the first step to address these points would be to re-analyse interviews, which would then allow me to refine my question to reflect the content of the interviews more justly.

Revisiting the data a few months later allowed me to realise this. After a period of rereading my interviews and looking at my initial analysis, I spent a week away from the data and this was an extract of a note from that time:

REMEMBER to keep stepping away from your analysis and give yourself a few days to allow ideas to percolate!!! How much easier was it to work out that the men were talking about identity stuff after you had a few days away from it?!?!?!?

As analysis went on, I slowly dawned upon the realisation that my initial research question which was based upon ideas of wellbeing and 'not knowing', was not resonating with the data set. This was highlighted partly through the actual transcripts, where participants simply gave my own words back to me:

SG: Can I ask what do you understand by the term wellbeing and how does that apply to you?

Mark: Well wellbeing is wellbeing in mental state, thinking the right way and being healthy you know. I'm sixty-one this year in August and I still play football, I play football every Saturday morning and go spinning on the Sunday morning, I don't do too much exercise, I don't like, well I keep doing exercises and keep working and it keeps the mind on the right track I think.

Or:

SG: ...the word wellbeing, what does that mean to you or for you?

James: Healthy, sound mind, that's it really.

The process of re-reading the interviews which was followed by a conversation with my academic supervisor, I realised how much my initial research was conceptualised using psychological terminology. During this conversation I was asked to summarise the content of my interviews by thinking about the 'stories the men were telling'. During this conversation I spoke about participants telling me about their journey through a system and that very little was said about wellbeing or 'not knowing' (concepts my interview schedule was devised upon). I recognised that interviews mostly focussed upon men's descriptions of managing the System around them. It was then that I realised that I had 'not been collaborating' with the men's interviews. Instead I realised that I had been trying to analyse my results through the lens of my 'knowledge of psychology'. If I had not brought concepts of wellbeing into the interview – I doubt the men would have used those words:

You're doing just what the diagnosis and schema therapy does to these men - imposing concepts of psychology, like 'wellbeing' onto them. Of course they're going to answer in terms of your words, but does it really mean something to them?

From this realisation, I questioned how I was going to conceptualise my new research aim. There was a large part of me that wanted to be a voice for the participants, whilst also wanting to keep a psychological focus to my research aims. It was at this point that I realised that being 'tighter' about my research aims actually meant 'loosening' the question. I felt that my epistemological position supported this change in focus:

The men don't and aren't talking to you about wellbeing or 'not knowing' in detail. It looks like they are telling you about what it is like for them to be transferred from prison and adjust to existing in a Total Institution. Perhaps this research is simply about experience and the regulations ofhospital.

I used my supervision with both my field and academic supervisors to try and hone my question, however quickly realised that they both had different visions for the direction of my thesis. On one hand, I had one supervisor who worked in the secure hospital, whom I had experienced as very supportive. She had been open with the fact that she found it harder to understand my epistemological position of social constructionist, and very much wanted my thesis to reflect on

the semantic ideas in my thesis about therapy being positive in the participants lives. On the other hand, my academic supervisor was very comfortable to embrace the social constructionist position and critique the hospital setting. Whilst I very much recognised that my supervisions were to guide my own ideas, there was the additional difficulty in actually knowing what my ideas were, as I wanted to please both supervisors:

ARRGGHHH! Who do I go with?!?!?! I feel like I'm stuck in the System!!!

After some distance and deliberation I reflected on the positions that both supervisors held. I reflected on the influence of my needing to please:

*The supervisor who I've seen most for my first submission is steeped in the organisation and is very much a part of the process of setting the agenda through her own position within the hospital. She is also incredibly caring and wanting to help the men she works for, this reflects why concepts of wellbeing and recovery were talked about so much in my supervisions. This process combined with my need to please, helps me recognise why these concepts are so dominant for me. Try and hold onto that these are **your** notions of therapy (and maybe the Hospital) and NOT necessarily the position of the men....*

Whilst I slowly came to the conclusion that I had a choice to make between a semantic level analyses or latent level, I reflected on my own thoughts about the world and what you can know:

I've realised that although the theoretical stance of social constructionism sits with my personal beliefs quite strongly, I am finding it hard to write up from this position. I am so used to trying to maintain my own 'position in the hierarchy' that I keep wanting to make psychology look good in my results. THE MEN ARE NOT SAYING THAT!!!

On reflection this above thought may have also been influenced by my own aspirations of helping. As a trainee entering the profession, I am influenced by a number of factors in my own identity. One strong influence is my own desire to help support individuals, whilst also being aware of wider political agendas, such as cuts to the NHS and the need for psychology as a profession to 'show it's worth'. These two influences are couched in a situation of me not yet being qualified, which adds another dimension of my wanting 'psychology to look good' in relation to my own identity. An interplay of these factors may have

influenced my ability to fully critique the powerful position of psychology in a more objective manner.

However, once I had reconciled this personal defence, the process of writing up became easier. I reflected on writing my introduction to my paper:

When I'm not trying to shoehorn concepts of 'wellbeing' and 'not knowing' into my thesis it flows much better. I hope this is because it reflects the interviews much better.....

The whole research process has taught me numerous things about qualitative research:

- The process needs to be given sufficient time.
- 'Absorbing' oneself in interview data requires the researcher to 'let go' of their own anxieties and embrace the position of the interviewee in order to truly reflect what is being said.
- The process requires flexibility – flexibility which I had perhaps not fully embraced initially!

My initial research question aimed to be based upon 'the impact of an unknown release date on wellbeing of people transferred from prison' and my final research question was 'the experience of being transferred from prison'. On reflection I believe this development may have additionally been partly shaped through the tension of doing social constructionist research in a doctoral setting. The very essence of inductive, social constructionist research methods suggest that a researcher approaches experiential data from those talking about 'lived experience' with no background literature review. This enables the researcher to approach the data with minimal preconceptions in order to focus upon the data more fully. This is something that I found very difficult due to my own personal process. My life on the course had required me to write a research protocol and a systematic literature review (of doctoral level standard, so required extensive research), prior to conducting my interviews. Although I had not realised it at the time, through completing this work, I found myself tied to ideas I came across through completing these, which perhaps tinted the lens of initial analysis. However, I believe that the research process has helped me resolve this - I am now exceptionally aware of how I am affected by my prior

knowledge. It will be something I will strongly hold in mind and give more consideration to when I conduct further qualitative research in the future.